OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-669-469

ISSUES

The parties stipulated to the average weekly wage, as previously admitted, in the amount of $983.79. The parties stipulated to Social Security disability offset based upon $1,486.20 per month, commencing December 1, 2007. The amount of the offset is $171.48 per week. During hearing the parties stipulated to the admission of the surveillance reports. Subsequently, the parties have filed with the Office of Administrative Courts the evidentiary deposition transcripts from their vocational experts; Katie Montoya for the Claimant and Pat Anctil for the respondents.

The sole issue for determination was permanent total disability.

FINDINGS OF FACT

1. The average weekly wage, per stipulation, is found to be $983.79. Per stipulation the respondents are entitled to an offset based upon $1,486.20 per month commencing December 1, 2007. The amount of the offset is $171.48 per week.

2. The claim was the subject of a Final Admission of Liability dated January 13, 2009. The Claimant was found to have reached maximum medical improvement on November 11, 2008 by Claimant's primary treating physician, Dr. David Richman. Dr. Richman provided his opinion that the Claimant sustained a 25% right upper extremity impairment, which could equal a 15% whole person if converted, and a 23% psychological impairment. Medical benefits after maximum medical improvement were admitted.

3. At the time of the hearing the Claimant was 60 years of age, being born on October 4, 1948. On September 30, 2005 the Claimant was gainfully employed as a truck driver for respondent-employer. On this date he lost consciousness while driving and was involved in a one-car accident. He sustained injuries, which have resulted in permanent impairment involving his right upper extremity, chronic pain syndrome and depression. The Claimant has undergone multiple surgeries to his shoulder in an effort to relieve the chronic severe pain emanating from his shoulder injury. The surgeries have, for the most part, been unsuccessful in relieving the Claimant of his severe pain.

4. The first surgery occurred on January 11, 2006 and was performed by Dr. Jan Davis. He performed a right shoulder arthroscopic debridement interarticular partial tearing of supraspinatus and subscapularis, as well as degenerative tearing of the superior glenoid labrum with scope assisted acromioplasty, partial distal claviculectomy, and partial evacuation of the periarticular cyst. The Claimant was no better after the surgery

and complained of more pain and stiffness in the shoulder. Claimant was followed by Dr. Douglas McFarland who treated him as the primary authorized treating physician. Claimant was involved in physical therapy for approximately three months during which time he did regain some of the shoulder motion but had continued significant pain over the lateral subacromial area. The Claimant was provided with narcotic medication for pain relief.

5. Due to the ongoing complaints, Dr. Davis recommended repeating MRI in April of 2006. The repeat study demonstrated partial thickness supraspinatus tear, as well as a large cyst in the supraspinatus muscle into the musculotendinous junction. Throughout the spring of 2006 the Claimant continued in physical therapy again without improvement. On May 3, 2006 Dr. Davis attempted to aspirate the right shoulder cyst and performed a steroid injection under ultrasound guidance. Dr. Davis then recommended proceeding with an open procedure. On June 13, 2006 Dr. Davis performed right shoulder open distal claviculectomy and debridement of the ganglion cyst. The Claimant continued with significant pain post-operatively. The Claimant was placed on Norco, as well as Cymbalta and also had trials of Lyrica.

6. In September of 2006 the Claimant attempted a trial return to work that was not successful. The Claimant was unable to tolerate work activities. At that point a second orthopedic recommendation was made and Dr. David Weinstein evaluated the Claimant on December 18, 2006. Dr. Weinstein was of the opinion that no further treatment would be beneficial. However, on January 10, 2007 a right shoulder MRI was performed noting full thickness tear distal infraspinatus tendon near its insertion site with fiber still intact and no retraction. The study also noted mild atrophy of the superspinatus and infraspinatus tendons as well as evidence of the previous acromioplasty.

7. The Claimant continued to be followed by Dr. Douglas McFarland who continued to try different medications to manage the Claimant's pain. In the spring of 2007 Dr. McFarland recommended psychological evaluation due to severe depression and the Claimant initially saw Dr. James Evans, Ph.D. on May 16, 2007. The Claimant continued counseling with Dr. Evans into July of 2008.

8. In July of 2007 the Claimant was seen by pain management anesthesiologist, Dr. Ronald Laub. Dr. Laub recommended proceeding with a TENS trial and felt the Claimant would be a candidate for a peripheral nerve stimulator. Dr. Laub also performed a subdeltoid bursa injection, which the Claimant notes was of no benefit.

9. The Claimant was then referred to Dr. Bart Goldman for evaluation. Dr. Goldman noted the history above-stated and assessed the Claimant as having a partial thickness tear of the right distal supraspinatus tendon, osteoarthritis, and subacromial bursitis of the right shoulder, status post surgeries, work-related, probable right suprascapular and/or axillary neuralgia secondary to the above diagnosis with CRPS II versus possible CRPS I. Dr. Goldman also felt the Claimant had a major depressive disorder with suicidal ideation, residual adhesive capsulitis right shoulder secondary to the above diagnoses, probable pain disorder with psychological factors in general medical condition, per-

sonality disorder, opiate dependency and a sleep dysfunction. Dr. Goldman recommended that the Claimant be evaluated by a third shoulder surgeon, Dr. Jon Erickson and recommended psychological evaluation. Dr. Goldman further recommended diagnostic testing including a thermogram, bone scan, and/or QSART testing. Dr. Goldman recommended that treatment be transferred from Dr. McFarland to a physiatrist. He recommended either Dr. David Richman or Dr. Keith Caughfield.

10. The Claimant was evaluated by Dr. Erickson on November 13, 2007. Dr. Erickson's impression was internal derangement of the right shoulder. Diagnostic studies were recommended. The Claimant underwent surgery by Dr. Jon Erickson on December 7, 2007 to repair a near full-thickness cuff tear with synovial cyst and severe impingement of the right shoulder. The procedure was a right shoulder arthroscopy, debridement, subacromial decompression, cuff repair and cyst excision. Post-surgically the Claimant failed to improve as hoped by Dr. Erickson. Dr. Erickson subsequently performed a right manipulation shoulder and injection of local anesthetic on April 22, 2008. Thereafter, Dr. Erickson had nothing further to recommend and the Claimant returned to Dr. Richman for follow-up care.

11. Dr. Richman has followed the Claimant since December 4, 2007. A variety of medications have been attempted to bring the Claimant's pain under better control. On December 16, 2008 Dr. Richman opined that the Claimant reached maximum medical improvement on November 11, 2008. Dr. Richman provided a 25% impairment for the right upper extremity which could be converted to a 15% whole person impairment. Dr. Richman also opined that the Claimant sustained a 23% whole person due to his psychological or mental disorder impairment. In his report of December 16, 2008 Dr. Richman opined, given his current level of impairment, particularly in the psychological disorder, "I do not think that [Claimant] is gainfully employable in any work environment." Medications were prescribed and continue to be prescribed on an indefinite basis.

12. Dr. James Evans followed the Claimant for his chronic pain and depression. Dr. Evans assessed the Claimant has having intractable right shoulder pain, reactive depression and anger with suicidal ideation. An attempt was made to refer the Claimant to a formal pain clinic in Denver. The Claimant attempted the pain clinic but did not feel that it would be beneficial to him. In his report of May 8, 2009 Dr. Evans provided,

> A review of my records would indicate that I first saw [Claimant] on or about May 16, 2007 upon a referral from Dr. Douglas McFarland. At that time, [Claimant], in my opinion, was struggling with chronic right upper extremity pain and I diagnosed pain disorder, which included symptoms of not only pain, but reactive depression, fear, anxiety, anger and significant sleep impairment.
>
> I saw [Claimant] for approximately 16 visits and last saw him in our Pueblo office on July 11, 2008. During that time, my treatment focused primarily on [Claimant]'s psychological response to his injury, to his multiple inva-

> sive procedures, and to the reactive symptoms of depression, fear, anger, anxiety, and sleep impairment.
>
> During the course of my approximately 14-month care of [Claimant], he was noted to be significantly depressed. At times, he presented at risk in terms of being a danger to himself or others.
>
> [Claimant] was prescribed a number of, I think, appropriate medications to include pain medications such as Oxycodone as well as a number of different psychiatric medicines to address his psychological problems. The medicines included at one time or another Cymbalta, Lexapro, Clonazepam, Trazadone, Ambien, Lunestra, and Paxil. Unfortunately, [Claimant] really had very limited perceived benefit from these medications and at the time of my last visit with [Claimant], on July 11, 2008, he continued to struggle with right shoulder pain with reactive depression, fear, anxiety regarding his future, anger regarding his income, and significant sleep impairment.

13. When asked to address what impediments there were from a psychological standpoint making it difficult for [Claimant] to function in a work setting, Dr. Evans stated, "It is my opinion that [Claimant]'s depression, which functionally presents as a very negative, sometimes sarcastic and very outspoken manner, would make it difficult for [Claimant] to interact socially or successfully with other employees, supervisors, and with the public if he was placed in a setting that required interaction with the public. Additionally, his sleep impairment and reliance of narcotics and sleep medications would affect his functionally cognitively and I would put him at danger in terms of operating a motor vehicle or working around heavy equipment."

14. When asked to comment on the evaluation at the pain clinic in Denver and [Claimant]'s decision not to complete the pain clinic, Dr. Evans stated, "Unfortunately, [Claimant], I think because of limited intellectual ability, limited medical understanding and because of his anger, skepticism and loss of confidence in physicians, was perceived not to be a good candidate for their program. . . . Unfortunately, [Claimant] does not have the capacity in my opinion to successfully complete that program."

15. Finally, Dr. Evans was asked to comment on how the chronic pain syndrome is affecting the Claimant, he stated,

> Clearly, as we see in chronic pain syndrome, the patients do develop psychological sequelae that often includes sleep impairment, reactive depression, and on occasion significant anger and risk of suicide and homicide. [Claimant] is a gentleman who has struggled since his injury with these symptoms and has essentially withdrawn socially. . . . Based on this anger, based on his frustration and limited insight, I would anticipate that these symptoms will continue to manifest themselves and will be exacerbated in times of stress and in situations where perception of his impairment is not

> understood. In summary, psychological symptoms that [Claimant] continued to exhibit on my last visit of July 11, 2008, I think would provide significant challenges and impediments to him in terms of successfully maintaining in the work place. Unfortunately, combined attempts of psychotropic medications and traditional education and psychotherapy have not resulted in significant alteration of those symptoms and it would be this writer's concern that [Claimant] might become an increased risk in terms of being a danger to himself or others in a work place setting.

16. At the hearing Dr. Richman provided testimony consistent with Dr. Evans in explaining the pain syndrome that is affecting the Claimant along with the chronic physical pain. Dr. Richman opined, as he did in his report above-referenced, that the Claimant was not capable of returning to the work place in light of his industrial injuries. Dr. Richman noted that the chronic pain creates a vicious cycle where chronic pain, depression and sleep deprivation make it exceedingly difficult for the Claimant to function outside of his home.

17. Prior to his testimony, Dr. Richman was provided with the videotaped surveillance that was submitted into evidence for his review. Dr. Richman noted that after reviewing the surveillance tape his opinion does not change as to whether the Claimant is capable of any type of sustained presence in the workforce. He acknowledged that the surveillance shows him performing some limited activities, which was in excess of what Dr. Richman felt he could do with his right upper extremity. Nonetheless, Dr. Richman noted that lifting your arm once or twice a day does not indicate that the Claimant is capable of working and reiterated his opinion that the Claimant was not capable, primarily from a psychological standpoint, from returning to work. The surveillance added nothing to Dr. Richman's understanding of his multiple work-related diagnoses.

18. It is found that the opinions and testimony provided by Dr. Richman and as found in the medical reports from Dr. Evans are persuasive and credible.

19. The video surveillance was the primary piece of evidence submitted by respondents in defense of the permanent total disability issue. The surveillance does not show the Claimant working or engaged in any type of repetitive activity of a physical nature. In addition, as noted by the investigator who performed the surveillance, Mike Ramirez, the surveillance tape was all of the surveillance that respondents had submitted even though the Claimant had been under surveillance a total of 12 days. The 24 minutes of video submitted into evidence hardly represents a significant version of what the Claimant does on a day-to-day basis, which is primarily secluded in his home dealing with his chronic pain. The surveillance reports that were submitted by stipulation, document that over the 12 days of surveillance the Claimant was predominantly not found to have left the home. This is entirely consistent with the testimony from the Claimant and Claimant's wife. Whereas the surveillance was reviewed along with the investigative reports, it is found to represent a snapshot of a few minutes of the Claimant's daily activities over an extended period of time and does not alter the findings that the Claimant has sus-

tained significant and permanent residuals, which, according to Dr. Evans and Dr. Richman, preclude the Claimant from returning to work as a result of his industrial injury.

20. The respondents also rely, in their defense of the issue, on the testimony from the vocational expert, Patricia Anctil. Ms. Anctil testified that in her opinion the Claimant was capable of earning wages. In support of her opinion, Ms. Anctil imposed her own restrictions unsupported by the medical evidence submitted by the primary treating physicians opined at or after maximum medical improvement. It is found that the testimony of the Claimant's vocational expert, Katie Montoya, was more persuasive than the testimony provided by respondents' expert, Patricia Anctil. The testimony and opinions from Patricia Anctil are not persuasive.

21. During her evidentiary deposition, the Claimant objected and moved to strike portions of Patricia Anctil's testimony as not having been produced prior to the evidentiary deposition. Specifically, Ms. Anctil testified concerning jobs she identified that were within the Claimant's ability to work. Because it is found that the Claimant has met his burden of proving that he is permanently and totally disabled, the Motion to Strike portions of Ms. Anctil's testimony is considered moot.

22. The Claimant presented the evidentiary deposition of Katie G. Montoya as his vocational expert. Ms. Montoya, based upon the medical records and her evaluation of the labor market, opined that the Claimant was not capable of earning any wages at this time. Ms. Montoya based her opinion not only upon the medical evidence but on the fact that the Claimant had a limited relevant work experience. She noted that the Claimant has primarily been a truck driver and, in the past, has worked as a welder on an oil rig, and as a surveyor for a brief period of time. Ms. Montoya did not find the past relevant work experience helpful in helping the Claimant to return to employment. She also noted that he has not been in an office-type setting nor does he have requisite computer skills to work in a sedentary position. Ms. Montoya further noted that the Claimant has limited education, having completed high school but not receiving any post high school degrees. Taking into consideration his age, his past relevant work experience, his current physical and psychological impediments, and the opinions from Drs. Richman and Evans, Ms. Montoya opined that the Claimant met the definition of permanent and total disability. Ms. Montoya's testimony is found to be persuasive.

23. The Claimant's wife, TP, testified. She testified that prior to the industrial injury her husband was a hard worker, loved to work, was outgoing, proud and independent. As a result of the injury, she now has to bathe and shave him, otherwise take care of him, keep track of his medications, and that his activities are severely limited.

24. The Claimant testified as to how the industrial injury has limited his ability to function in and outside of the home. He testified that the chronic pain prevents him from performing any sustainable activity. His testimony was consistent with Dr. Evans, Dr. Richman, and Katie Montoya. It is found that the testimony provided by the Claimant and his wife, TP, was credible and persuasive as to the effects of the industrial injury on his ability to function in and outside of the home.

25. It is found that the Claimant has demonstrated that it is more likely than not that he is permanently and totally disabled as a result of the industrial injury of September 30, 2005. It is further found that Claimant has proven that the industrial injury is a significant causative factor in his current disability.

CONCLUSIONS OF LAW

Based upon the Findings of Fact, the Administrative Law Judge makes the following Conclusions of Law:

1. Permanent total disability is defined by Section 8-40-201(16.5)(a) as the Claimant's inability "to earn any wages in the same or other employment." The burden of proof to establish the Claimant suffers from a permanent total disability lies with the Claimant and is a question of fact for the Administrative Law Judge. *Holly Nursing Care Center v. Industrial Claim Appeals Office*, 992 P.2d 701 (Colo. App. 1999). In arriving at a factual determination as to whether the Claimant has sustained her burden of proof, the Administrative Law Judge may consider several "human factors" in making the decision. *Christie v. Coors Transportation Co.*, 933 P.2d 1330 (Colo. 1997); *Best-Way Concrete Co. v. Baumgartner*, 908 P.2d 1194 (Colo. App. 1995). These factors include, but are not limited to, the Claimant's physical condition, mental ability, age, employment history, education and the "availability of work" the Claimant can perform. *Weld County School District RE-12 v. Bymer*, 955 P.2d 550 (Colo. 1998). It is the overall objective of this "human factor" standard to determine whether, when taking into account all of the relevant factors, employment is "reasonably available to the Claimant under his or her particular circumstances." *Weld County School District RE-12 v. Bymer*, supra. Non-industrial medical conditions that impair the Claimant's ability to earn wages can be considered when performing a "human factor" analysis. *Pinkard v. Jefferson County School*, W.C. No. 4-174-632 (ICAO March 18, 1998).

2. An industrial injury does not need to be the sole cause of the Claimant's permanent and total disability. Because of the "full responsibility rule" an employer takes an injured worker as it finds him, and permanent total disability can be a combination of personal factors, such as a pre-existing mental or physical condition and a work-related injury or disease. *Climax Molybdenum Co. v. Walter*, 812 P.2d 1168 (Colo. 1991); *Colorado Fuel & Iron Corp. v. Industrial Commission*, 379 P.2d 153 (Colo. 1962); *Casa Bonita Restaurant v. Industrial Commission*, 624 P.2d 1340 (Colo. App. 1981). The Claimant must demonstrate that the industrial injury is a significant causative factor in the Claimant's disability to establish permanent and total disability. *Seifried v. Industrial Commission*, 736 P.2d 1262 (Colo. App. 1986); *Riley v. Mile High Honda*, W.C. No. 4-486-242 (ICAO August 12, 2003); *Garcia v. CF&I Steel, L.P.*, W.C. No. 4-454-548 (ICAO May 14, 2004). In the instant case the Claimant has provided the most persuasive evidence that he is permanently and totally disabled and that the industrial injury of September 30, 2005 is a significant factor in his permanent and total disability.

3. The Claimant has undergone multiple surgeries and other treatment to improve his condition. The Claimant has significant and permanent residuals which, according to Dr. Evans and Dr. Richman, preclude the Claimant from returning to work as a result of his industrial injury. The vocational expert, Katie Montoya, supports Claimant's position and has opined that he is incapable of earning any wages as previously found in Paragraph 22. The most persuasive evidence establishes that the Claimant has met his burden of proof that he is now permanently and totally disabled as a result of this industrial injury. The human factors have been explored. The combination of his age, loss of access to the type of jobs he has performed in the past, his lack of education, and the almost overwhelming effects of the chronic pain and depression preclude the Claimant from earning any wages. Respondents' argument that Claimant is exaggerating his physical limitations and therefore is not credible is not persuasive. The Claimant has undergone years of treatment to try to improve his condition including multiple painful surgeries. In addition, the treating doctors have based their opinions on the objective evidence. There is no question Claimant has sustained severe injuries. The primary evidence submitted by respondents is the surveillance tape and the opinion from Ms. Patricia Anctil. As previously found the testimony from Patricia Anctil was not found to be persuasive and the surveillance tape only has limited weight as found by the Administrative Law Judge.

4. Respondents shall be ordered to pay permanent total disability benefits commencing on the date of maximum medical improvement on November 11, 2008 as a result of the September 30, 2005 industrial injury.

ORDER

It is therefore ordered that:

1. The Respondent-Insurer shall pay Claimant for permanent total disability benefits commencing November 11, 2008 at the rate of $484.38 per week.

2. The Respondent-Insurer shall pay interest to Claimant at the statutory interest rate of eight percent (8%) on all amounts of compensation not paid when due.

3. All matters not determined herein are reserved for future determination.

DATE: October 1, 2009
/s/ original signed by:

Donald E. Walsh

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-755-760

ISSUES

- Whether Claimant is entitled to temporary total disability (TTD) benefits commencing on September 19, 2008.
- Whether Claimant was responsible for termination of her employment.
- Respondents stipulated that they waived the right to challenge the DIME opinion dated September 10, 2008.

FINDINGS OF FACT

1. On March 16, 2008, Claimant sustained an admitted injury to her left wrist and left knee when she tripped and fell.

2. Claimant received medical treatment with Exempla, and on April 15, 2008, Dr. Steve Cobb restricted Claimant from lifting, carrying, pushing, pulling, crawling, kneeling, squatting or climbing, and sitting duty only.

3. On April 23, 2008, Dr. John Sacha placed Claimant at maximum medical improvement (MMI) and assigned a 0% impairment rating with no work restrictions.

4. Respondents filed a Final Admission of Liability (FAL) on May 19, 2008, admitting to temporary total disability (TTD) benefits from March 17, 2008, through April 28, 2008.

5. Claimant timely objected to the FAL and applied for a Division Independent Medical Examination (DIME).

6. Claimant underwent a DIME with Dr. Lynn Parry on September 10, 2008. On September 30, 2008, Dr. Parry issued a report finding that Claimant had not reached MMI and recommended further evaluation by an orthopedist for her knee and by a hand surgeon for her wrist.

7. Employer is a fast food restaurant chain. Claimant's job duties included cleaning the lobby, cleaning the restrooms, picking up trash inside the lobby, and picking up trash in the parking lot. Claimant returned to work for Employer with restrictions after she was placed at MMI on April 23, 2008.

8. During Claimant's work shift on September 18, 2008, Claimant became involved in a verbal confrontation with her supervisor whose name is Wright.

9. On September 18, 2008, Wright arrived for her shift and performed her usual inspection of the restaurant as required by the Employer. Wright noticed the women's restroom required attention and asked another employee if she knew the Claimant's whereabouts.

10. The employee directed Wright to the building's parking lot where Wright observed the Claimant outside in the parking lot by a parked vehicle. Wright observed the Claimant bent over into the car taking bread from another co-worker.

11. Wright approached the Claimant from behind and called the Claimant's first name twice. Claimant did not respond, so Wright tapped Claimant on the shoulder. Claimant turned around and threw her hands up into the air and began yelling at Wright.

12. Wright told Claimant that the restroom needed attention, however the Claimant continued yelling at Wright. Wright asked Claimant what was wrong with her.

13. Claimant repeatedly testified that Wright grabbed her left wrist then pushed her and that she needed to throw her arms up to force Wright to release her arm. Claimant also testified she did not understand Wright because Wright was speaking English. Claimant later testified she understood that Wright was directing her to go inside to clean the restroom.

14. Claimant's daughter, Bermea, witnessed a portion of the incident. Bermea was inside the restaurant when she witnessed Claimant's arms up in the air. Bermea did not witness Wright grab or push Claimant. Bermea assumed that Wright grabbed Claimant because she saw Claimant throw her arms up in the air. Bermea approached Wright and asked, "why did you hit my mother" and Wright responded "I didn't do anything to your mom."

15. Wright told the Claimant to leave for the day. Following the verbal confrontation, Wright left the Employer's premises and began calling the former store manager, Flores.

16. Flores was the store manager in September 2008. Flores' duties included hiring employees, scheduling employees, and terminating employees. Flores hired the Claimant in February 2008 as a "lobby person." Flores testified the Claimant understands English quite well.

17. While Wright was attempting to contact Flores, Bermea contacted the police to report the confrontation between the Claimant and Wright.

18. Another person claimed to witness the confrontation between Wright and Claimant. Claimant's former neighbor, Santiago, was in her vehicle stopped at a stoplight on Colorado Boulevard in front of the Employer's building. Santiago testified that she saw and heard Wright arguing with Claimant, but could not understand because she does not speak English. Santiago testified that the argument was loud. Santiago testified that after hearing the argument, she saw Wright grab Claimant's arm and heard Claimant tell Wright to let go of her. Santiago then pulled into the parking lot to purchase food and ask if Claimant was okay.

19. According to Claimant, the verbal argument did not occur until after Wright allegedly grabbed her arm and pushed her. Santiago testified that she was concerned that

Claimant was being abused yet Santiago did not mention Wright pushing the Claimant as Claimant repeatedly testified. Santiago's version of the events lacks credibility due to the inconsistencies with Claimant's version of the events, which also lacks credibility.

20. Upon Wright's return to the Employer's premises the police had arrived. Wright was speaking with Flores on the phone while waiting to be questioned by the police. It is undisputed the police, after speaking with all parties and witnesses involved, chose not to issue Wright a ticket or citation.

21. Claimant was involved in a prior confrontation at work with Flores. Approximately two to three weeks prior to the confrontation with Wright, Claimant had an emotional outburst after Flores asked her a question in Spanish about music CDs. Claimant apparently misunderstood the question and became upset and responded aggressively saying things that did not make sense to Flores. Flores followed the Claimant to the "crew room" attempting to address the misunderstanding. The Claimant eventually left the building and was crying. Flores followed the Claimant to the parking lot to attempt to address the misunderstanding. Flores eventually calmed the Claimant and she returned to work her scheduled shift.

22. Flores spoke with Wright regarding the confrontation on September 18, 2009; however, Flores did not witness the confrontation and did not speak with the police.

23. Flores reported both confrontations to his supervisor. The supervisor advised Flores that the Claimant's employment should be terminated.

24. Prior to the termination, Employer was accommodating Claimant's physical restrictions and Claimant was able to work within those restrictions.

25. Based on the foregoing, Respondents have established that Claimant was responsible for the termination of her employment. Claimant was terminated due to her inappropriate and confrontational behavior in the workplace, which was within her control.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102 (1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 593 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936), CJI, Civil 3:16 (2007).

Responsibility For Termination/ Entitlement to TTD

4. Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., (termination statutes) provide that, where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury. Respondents shoulder the burden of proving by a preponderance of the evidence that Claimant was responsible for her termination. *See Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 20 P.3d 1209 (Colo. App. 2000).

5. By enacting the termination statutes, the General Assembly sought to preclude an injured worker from recovering temporary disability benefits where the worker is at fault for the loss of regular or modified employment, irrespective whether the industrial injury remains the proximate cause of the subsequent wage loss. *Colorado Springs Disposal v. Martinez*, 58 P.3d 1061 (Colo. App. 2002) (court held termination statutes inapplicable where employer terminates an employee because of employee's injury or injury-producing conduct). An employee is "responsible" if the employee precipitated the employment termination by a volitional act which an employee would reasonably expect to result in the loss of employment. *Patchek v. Colorado Department of Public Safety*, W.C. No. 4-432-301 (September 27, 2001). Thus, the fault determination depends upon whether claimant performed some volitional act or otherwise exercised a degree of control over the circumstances resulting in termination. *Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1994), *opinion after remand*, 908 P.2d 1185 (Colo. App. 1995). That determination must be based upon an examination of the totality of the circumstances. *Id.*

6. As found, Respondents have established by a preponderance of the evidence that Claimant was responsible for the termination of her employment. Claimant was terminated due to her inappropriate and confrontational behavior in the workplace following a second confrontation with a supervisor. Claimant and her supervisor, Wright, provided conflicting accounts of the incident that resulted in the termination. The Judge resolves the conflict in favor of Respondents as Claimant's testimony lacked credibility. The versions of the events provided by Claimant, Santiago and Bermea were inconsistent. Most notably, no one testified that Wright pushed Claimant although Claimant repeatedly testified that she was pushed. Given Santiago's concern for the Claimant and

her assertion that she saw the entire incident, it stands to reason that she would have reported seeing Wright push the Claimant had it actually happened as Claimant described. Based on Wright's credible testimony, it is more probably true than not that Wright tapped Claimant on the shoulder and Claimant overreacted by throwing up her arms and yelling at Wright. Such behavior was within Claimant's control.

7. Based upon the totality of the circumstances, Claimant's inability to control her behavior in the work place ultimately resulted in her termination. Claimant's behavior of yelling at a supervisor constituted a volitional act which she would reasonably expect to result in loss of her employment. Claimant is responsible for the termination of her employment. Sections 8-42-103(1)(g) and 8-42-105(4), C.R.S., preclude Claimant from receiving temporary disability benefits.

ORDER

It is therefore ordered that:

1. Claimant was responsible for the termination of her employment. Accordingly, Claimant's claim for temporary disability benefits is denied and dismissed.
2. All matters not determined herein are reserved for future determination.

DATED: October 1, 2009

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-787-165

ISSUE

Whether Claimant has established by a preponderance of the evidence that total left hip replacement surgery is related to her December 19, 2008 industrial injury and is reasonable and necessary to relieve the effects of the injury.

FINDINGS OF FACT

1. Claimant worked for Employer as a dental hygienist. On December 19, 2008 Claimant suffered an industrial injury when she fell down exterior stairs on Employer's premises. Claimant testified that she slipped on ice and snow while descending the stairs and landed on her left side and hip. She noted that her left leg bent at an unusual angle during the incident. Claimant experienced left knee, left hip and lower back pain following the accident.

2. Claimant subsequently obtained medical treatment for her injuries at Kaiser Permanente. On December 29, 2008 she visited Paul Fournier, M.D. for an evalua-

tion. Dr. Fournier recounted the mechanism of injury and Claimant's pain symptoms. He diagnosed Claimant with left knee, left hip and lumbar strains. Dr. Fournier referred Claimant for physical therapy, prescribed medications and imposed restrictions on lifting, sitting, standing, and walking.

3. On January 26, 2009 Claimant returned to Dr. Fournier for an examination. She reported that her knee pain had improved with physical therapy and medications but she continued to experience left hip and lower back pain. Dr. Fournier obtained an x-ray of Claimant's left hip that revealed pronounced degenerative changes with loss of joint space and remodeling of the left femoral head. However, the x-ray was negative for fractures or ligament damage. Dr. Fournier modified his diagnosis concerning Claimant's left hip to "acute on chronic aggravation of underlying DJD." He directed Claimant to continue physical therapy and return in two to three weeks.

4. On February 16, 2009 Claimant again visited Dr. Fournier for an examination. He directed Claimant to continue physical therapy and referred her for an orthopedic evaluation with Rajesh Bazaz, M.D.

5. On February 25, 2009 Claimant visited Dr. Bazaz. Dr. Bazaz noted that an x-ray of Claimant's left hip revealed "advanced bone on bone arthrosis." He characterized Claimant's condition as advanced left hip osteoarthritis with recent trauma. Dr. Bazaz commented that there was a lack of similar findings in the right hip. He recounted that Claimant had not reported any prior hip symptoms and that she had actively engaged in hiking and walking prior to the December 19, 2008 incident. Dr. Bazaz recommended a total left hip replacement for Claimant because her hip was "far too advanced" for other treatment. He concluded that the December 19, 2008 incident had exacerbated Claimant's pre-existing osteoarthritis condition.

6. Claimant returned to Dr. Fournier in March 2009. He noted that she continued to suffer from multiple problems. Regarding Claimant's left hip, Dr. Fournier remarked that if she had not fallen on December 19, 2008 she would not have required a hip replacement. Nevertheless, because of the severity of her degenerative condition she would have required a hip replacement at some point in the future.

7. On April 27, 2009 Claimant visited James P. Lindberg, M.D. for an independent medical examination. Dr. Lindberg explained that Claimant suffered from significant degenerative arthritis of the left hip. He noted that hip replacement surgery was medically reasonable but that the need for surgery was "100% preexisting" because of her osteoarthritis. Dr. Lindberg commented that Claimant's industrial injury might have aggravated her condition but her symptoms also could have been aggravated during her activities of daily living. He concluded that Claimant would have required a total left hip replacement at some point regardless of the December 19, 2008 incident.

8. On July 21, 2009 the parties conducted the evidentiary deposition of Dr. Fournier. He testified consistently with his medical reports that the December 19, 2008 incident aggravated Claimant's pre-existing left hip osteoarthritis. Dr. Fournier explained that despite Claimant's degenerative osteoarthritis she could have remained asympto-

matic prior to her slip and fall. He thus remarked that the incident aggravated her previously asymptomatic osteoarthritis. Dr. Fournier opined that the December 19, 2008 incident caused a permanent aggravation of Claimant's condition. He concluded that the December 19, 2008 slip and fall accelerated Claimant's need for left hip replacement surgery.

9. On August 26, 2009 the parties conducted the evidentiary deposition of Dr. Lindberg. He explained that Claimant has suffered from degenerative arthritis in her left hip for years. Dr. Lindberg opined that Claimant's condition was not caused by the December 19, 2008 incident and that her need for a hip replacement was based on her pre-existing degenerative condition of "severe end stage osteoarthritis." He noted that Claimant would have required a left hip replacement regardless of whether she injured her hip on December 19, 2008. Nevertheless, Dr. Lindberg acknowledged that an accident similar to the one suffered by Claimant could cause an asymptomatic arthritic condition to become symptomatic. He also recognized that he would not perform hip replacement surgery if a degenerative arthritic condition was not symptomatic.

10. Claimant testified that she had not suffered from left hip symptoms prior to the December 19, 2008 incident. She remarked that she had engaged in a number of outdoor activities including biking and hiking prior to the incident. However, subsequent to December 19, 2008 she has been unable to resume her numerous outdoor activities.

11. Claimant's credible testimony and the persuasive evidence of doctors Bazaz and Fournier demonstrate that Claimant has established it is more probably true than not that her left hip condition is related to her December 19, 2008 industrial injury. Moreover, hip replacement surgery is reasonable and necessary to cure and relieve the effects of Claimant's left hip injury. Claimant's December 19, 2008 slip and fall aggravated, accelerated, or combined with her pre-existing degenerative osteoarthritis to produce a need for left hip replacement surgery. Claimant testified that she injured her left hip on December 19, 2008 when she slipped and fell on Employer's exterior stairs. She noted that she had not experienced left hip symptoms prior to the incident. Dr. Bazaz reported that the December 19, 2008 incident had exacerbated Claimant's pre-existing degenerative osteoarthritis condition and she required hip replacement surgery. Dr. Fournier concurred that Claimant suffered from pre-existing osteoarthritis in her left hip and that the December 19, 2008 incident caused a permanent aggravation of her condition. He persuasively concluded that Claimant's slip and fall accelerated her need for left hip replacement surgery. Although Dr. Lindberg opined that Claimant's need for a left hip replacement was based strictly on her pre-existing severe end stage osteoarthritis, his opinion is not persuasive because it fails to acknowledge that Claimant was asymptomatic before the December 19, 2008 incident and that the incident accelerated her need for hip replacement surgery.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-

102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). Nevertheless, the claimant bears the burden of demonstrating a causal connection between a work-related injury and the condition for which benefits are sought. *In Re Abeyta,* W.C. No. 4-669-654 (ICAP, Jan. 28, 2008). A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). The determination of whether medical treatment is necessitated by a compensable aggravation or a mere worsening of a pre-existing condition is a question of fact for the ALJ. *In Re Abeyta,* W.C. No. 4-669-654 (ICAP, Jan. 28, 2008). When the record contains conflicting expert opinions the ALJ is charged with resolving the conflict. *Id.*

5. As found, Claimant's credible testimony and the persuasive evidence of doctors Bazaz and Fournier demonstrate that Claimant has established by a preponderance of the evidence that her left hip condition is related to her December 19, 2008 industrial injury. Moreover, hip replacement surgery is reasonable and necessary to cure and relieve the effects of Claimant's left hip injury. Claimant's December 19, 2008 slip and fall aggravated, accelerated, or combined with her pre-existing degenerative osteoarthritis to produce a need for left hip replacement surgery. Claimant testified that she injured her left hip on December 19, 2008 when she slipped and fell on Employer's exterior stairs. She noted that she had not experienced left hip symptoms prior to the incident. Dr. Bazaz reported that the December 19, 2008 incident had exacerbated

Claimant's pre-existing degenerative osteoarthritis condition and she required hip replacement surgery. Dr. Fournier concurred that Claimant suffered from pre-existing osteoarthritis in her left hip and that the December 19, 2008 incident caused a permanent aggravation of her condition. He persuasively concluded that Claimant's slip and fall accelerated her need for left hip replacement surgery. Although Dr. Lindberg opined that Claimant's need for a left hip replacement was based strictly on her pre-existing severe end stage osteoarthritis, his opinion is not persuasive because it fails to acknowledge that Claimant was asymptomatic before the December 19, 2008 incident and that the incident accelerated her need for hip replacement surgery.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Respondents are financially responsible for Claimant's total left hip replacement surgery.

2. All issues not resolved in this order are reserved for future determination.

DATED: October 1, 2009.

Peter J. Cannici

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-698-452 & WC 4-760-753

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that he sustained an occupational disease proximately caused by the hazards of his employment at MC or Arlo?

¬ If the claimant proved that he sustained a compensable occupational disease, do the principles of last injurious exposure and substantial permanent aggravation place liability for indemnity benefits on the Arlo respondents?

¬ If the claimant proved that he sustained a compensable occupational disease, which of the respondents was "on the risk" for purposes of liability for medical benefits?

¬ Are the MC respondents estopped from seeking to impose liability on the Arlo respondents for the alleged occupational disease because they "waived" this right by failing to raise it in a prior proceeding?

¬ If the ALJ finds the claimant failed to prove that he sustained a compensable occupational disease with respect to the Arlo respondents, do principles of claim closure and/or issue preclusion prevent the ALJ from reaching the same conclusion with respect to the MC respondents?

¬ Did the claimant prove by a preponderance of the evidence that he is entitled to an award of temporary total disability benefits commencing April 1, 2008?
¬ Did the claimant prove by a preponderance of the evidence that one or the other of the respondents is liable to provide medical benefits commencing April 17, 2008?
¬ What is the claimant's average weekly wage?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

1. WC 4-698-452 involves a claim for benefits against the MC respondents. WC 4-760-753 involves a separate claim for benefits against the Arlo respondents. Because these claims involve common issues of fact and law, PALJ Fitzgerald ordered that they be consolidated for purposes of hearing. ALJ Jones subsequently affirmed PALJ Fitzgerald's decision to consolidate the claims. The undersigned ALJ has determined that it is best to enter a single order addressing the issues in both claims.
2. The claimant was employed by MC (__) from 1973 until January 28, 2007, when he "retired" from MC. The claimant worked as an over the road truck driver from 1973 to 1988. Thereafter, the claimant drove a truck in town delivering various items including bottles and beer.
3. The claimant credibly testified concerning the duties associated with driving a truck in town. He was frequently required to "dolly" trailers up and down by operating a hand crank. This duty required bending and twisting. The truck suspensions were stiff and caused a rough ride resulting in significant amounts of vibration, bumping and jarring of the driver. The claimant was not required to load or unload the trucks, but on some days he was required to sit in the truck for several hours waiting for others to load or unload the truck.
4. In early 2007 MC outsourced its trucking operations to Arlo. On February 1, 2007, the claimant began work as an employee of Arlo. The claimant continued performing the same duties and operating the same trucks as he did when he was MC's employee.
5. In 1982 the claimant sustained a work related back injury when he slipped off of a fuel tank and fell on his buttocks. The claimant sustained a back injury that ultimately necessitated a lumbar laminectomy at the L5-S1 level. The claimant recovered from this surgery and returned to his regular employment without significant residual symptoms. However, the claimant admitted that he believed he could sometimes forecast changes in the weather after this injury.
6. In 2000 the claimant sustained another work related back injury while climbing up a stair onto a truck. This injury ultimately resulted in a left L3-4 laminotomy, discectomy and nerve root decompression. As a result of this injury the claimant received a 24% whole person impairment rating from a Division-sponsored independent medical examination (DIME) physician. The claim for this injury was assigned WC No. 4-538-972.
7. After his release from the 2000 injury the claimant recovered well and was able to resume his regular employment as a truck driver. However, in 2002 and 2003 the claimant occasionally experienced backaches. He did not seek medical treatment for these problems.

8. The claimant testified that beginning in 2004 his left leg would sometimes become “gimpy.” Early in 2005 the claimant experienced “tingling” in the leg as well as back pain.
9. In July 2005, the claimant sought treatment from his personal physician, Dr. Hai P. Bui, M.D. The claimant reported low back pain without lower extremity pain or weakness, and without numbness.
10. On November 29, 2005, the claimant came under the care of Dr. A. Andrew Castro, M.D. The claimant reported symptoms of low back pain, right buttock pain, right groin pain, anteriomedial leg pain with right greater than left. The claimant reported difficulties with his gait. The claimant also described neck pain and weakness in the left upper extremity. Dr. Castro noted that imaging studies revealed multilevel degenerative changes of the lumbar spine. He prescribed an MRI of the lumbar spine.
11. A lumbar MRI was performed on December 5, 2005. The radiologist noted a “small left central/paracentral disc extrusion at L4-5 impinging on the left L5 nerve root.” There was no evidence of a recurrent disc at L3-4. Mild progression of diffuse lumbar degeneration was noted. Osteoarthritis at L4-5 and L5-S1 was observed to be stable, as was mild bilateral formainal stenosis at L5-S1.
12. Dr. Castro also procured a cervical MRI that revealed severe cervical stenosis at several levels. On December 29, 2005, Dr. Castro recommended cervical decompression surgery, which he performed on February 22, 2006. The claimant’s cervical and upper extremity problems and the resulting surgery are not alleged to have resulted from the claimant’s employment at MC or Arlo.
13. After recovering from the neck surgery the claimant returned to work at his regular duties. However, the low back and lower extremity symptoms continued.
14. On May 4, 2006, Dr. William Shaw, M.D., performed an independent medical examination (IME) at the request of MC. The claimant reported pain in his low back and both legs. The claimant also reported some weakness and that his left leg was “giving out”. Dr. Shaw opined the claimant’s symptoms were most probably the result of the natural progression of his degenerative spinal processes and unrelated to his employment and prior injuries at MC.
15. Dr. Castro examined the claimant on May 11, 2006. At that time the claimant reported “a burning sensation in [the] right anterolateral and anterior thigh.” Dr. Castro reviewed the MRI and noted the claimant had “very significant degenerative changes at multiple levels which could be contributing to his present neurogenically claudicatory symptoms.” Dr. Castro stated that he intended to refer the claimant to Dr. Douglas Hemler, M.D. for epidural steroid injections (ESI) “before we consider any surgical intervention for his low back.”
16. The claimant testified that at some point in 2006 Dr. Castro recommended that he undergo lumbar fusion surgery. Although there is no medical documentation that Dr. Castro ever recommended a fusion surgery, his May 11, 2006, office note demonstrates that at that point he discussed with the claimant the possibility of some type of low back surgery.
17. Dr. Hemler treated the claimant on May 23, 2006. Dr. Hemler diagnosed lumbar spondylosis with left L4-5 and L5-S1 leg pain. Dr. Hemler performed a “left L4-5 and L5-S1 transforaminal epidural steroid injection.”

18. On August 8, 2006, Dr. John Hughes, M.D., performed an IME at the claimant's request. The claimant reported low back pain and pain radiating into the right leg at the end of the workday. The claimant stated he received good relief for one week after Dr. Hemler performed the ESI. Dr. Hughes opined the December 2005 MRI finding of a "lateralizing disc protrusion" at L4-5 was "confusing" because it did not correlate with the claimant's symptoms of "right lateralizing low back pain" and a mildly positive right straight leg raise. Dr. Hughes stated the claimant's symptoms appeared to be generated at the L5-S1 level. Dr. Hughes opined these symptoms represented the natural progression of the 1982 injury, and that the degenerative process is "likely to have been measurably accelerated by prolonged seated position of 6-7 hour a day in the course of truck driving."

19. On October 25, 2006, the claimant visited with Dr. Philip Smaldone, M.D., of "Coors Occupational Medicine." The claimant was seeking approval for payment of the injections performed by Dr. Hemler in May 2006. In a report dated November 16, 2006, Dr. Smaldone expressed the opinion that considering the claimant's "extensive progressive" spinal disease involving both the lumbar spine and the cervical spine he could not state the need for injections was related to an occupational disease resulting from the claimant's activities as a truck driver.

20. At some point in time the claimant sought to reopen the claim for the 2000 injury (WC 4-538-972) alleging that he sustained a worsening of condition that caused the need for additional medical treatment of his low back and leg symptoms. Alternatively he filed a new claim for benefits (WC 4-698-452) alleging the need for treatment was the result of a separate occupational disease caused by the performance of his duties at MC. On April 12, 2007, (approximately three months after the claimant began work for Arlo) ALJ Jones heard these claims. By Supplemental Order dated November 20, 2007, ALJ Jones denied the petition to reopen WC 4-538-972. However, relying heavily on the opinions of Dr. Hughes, ALJ Jones found the claimant proved that he sustained an occupational disease in WC 4-698-452. Specifically, ALJ Jones determined the claimant's employment as a truck driver at MC caused an aggravation and/or acceleration of his pre-existing degenerative back condition. Accordingly, ALJ Jones ordered the MC respondents to pay for medical treatment rendered by Dr. Smaldone on November 16, 2007, and for treatment rendered by Dr. Castro and Dr. Hemler *after* that date. In the Supplemental Order ALJ Jones specifically stated that, "All matters not determined herein are reserved for future determination."

21. On April 8, 2008, the Industrial Claim Appeals Office (ICAO) entered an Order affirming the determination of ALJ Jones that the claimant sustained an occupational disease while employed by MC. However, the ICAO remanded the matter to determine whether the MC respondents "waived" the issue of "shifting liability" for the medical benefits to the Arlo respondents by failing to raise the issue in a timely fashion.

22. On July 8, 2008, ALJ Jones entered an Order on Remand determining that the MC respondents had waived the issue of "shifting liability" for medical benefits to the Arlo respondents by failing to plead the issue in a timely fashion. The MC respondents petitioned the ICAO for review of this order.

23. On December 15, 2008, the ICAO entered a Final Order affirming the July 8, 2008, order of ALJ Jones. The record contains no credible or persuasive evidence that the ICAO's Final Order was appealed and the ALJ infers it was not.

24. The claimant credibly testified that he did not want to return to Dr. Castro for additional treatment because he preferred to avoid the surgery that he believed Dr. Castro was recommending. As a result, the claimant, acting on his own, sought treatment from Dr. Alan T. Villavicencio, M.D.

25. Dr. Villavicencio first examined the claimant on February 6, 2007, less than a week after the claimant commenced work with Arlo. The claimant reported symptoms of "low back pain with left groin discomfort." The claimant stated that he was "unable to sit, stand, climb in an out of the truck, or do pretty much any other activity." Dr. Villavicencio expressed concern the claimant was suffering from a left L1-2 disc herniation causing left L2 radiculopathy, and possibly a hernia. Dr. Villavicencio referred the claimant for a left L2 nerve block, and expressed hope that "we can do a simple left L1-2 microdiscectomy for pain relief" while avoiding a fusion.

26. On February 14, 2007, the claimant underwent radiological studies and a CT scan of the pelvis. These studies revealed "extensive degenerative changes in the lower lumbar spine with severe narrowing of the L4-5 and L5-S1 disc spaces." Prominent degenerative changes in both hip joints were also noted.

27. No L1-2 block was performed because an MRI revealed no significant neural impingement at that level. However, on April 4, 2007, Dr. Justin Green, M.D. performed EMG studies which showed no clear electrodiagnostic evidence of an ongoing left lower extremity radiculopathy. Dr. Green recommended another MRI with contrast for comparison to the claimant's prior MRI. On April 24, 2007, Dr. Green also performed an L5-S1 ESI. However, this injection provided only minor relief for 24 hours.

28. On April 9, 2007, the claimant underwent a lumbar MRI "without and with contrast." The radiologist, Dr. Roger Nichols, M.D., compared the April 2007 MRI to the claimant's December 2005 MRI. At L2-3 Dr. Nichols noted diffuse annular bulging contributing to mild-moderate foraminal narrowing. This finding was described as "similar to prior study." At L3-4 Dr. Nichols noted there had been a prior left hemilaminectomy and there was moderate left-sided foraminal narrowing secondary to broad-base disc bulging. At L4-5 Dr. Nichols observed a central disc protrusion that was smaller than on the previous examination and mildly narrowing the left foramina. At L5-S1 Dr. Nichols observed broad-base annular bulging contributing to moderate bilateral foraminal encroachment, right greater than left.

29. On May 17, 2007, the claimant advised Dr. Villavicencio's physician's assistant that he was anxious to proceed with surgical intervention because all conservative options had failed.

30. The claimant again changed physicians because he felt that Dr. Villavicencio was not sufficiently available to treat him.

31. On March 3, 2008, the claimant sought treatment from Dr. Kenneth Pettine, M.D. The claimant obtained this treatment outside of the workers' compensation system because he did not want to file a claim against the Arlo respondents and did not understand that he might still have a claim against the MC respondents.

32. On March 3, 2008, the claimant reported to Dr. Pettine that he was experiencing severe bilateral leg pain and some back pain. Dr. Pettine reviewed the 2007 MRI scan and noted diffuse areas of stenosis, especially at L4-5. He advised the claimant that the options included living with the symptoms, epidural injections, or a decompression surgery at L4-5 and possibly other levels.

33. The claimant elected to undergo surgery. On April 1, 2008, Dr. Pettine performed a bilateral hemilaminectomy, medical facetectomy, and foraminotomy at L2-3 and L4-5. On April 10, 2008, the claimant reported he was doing well and was basically asymptomatic.

34. Dr. Pettine examined the claimant on July 28, 2008. Dr. Pettine noted the claimant stated the surgery "helped his legs" but they continued to be symptomatic. Dr. Pettine observed the claimant had an "antalgic gait" and difficulty getting on his toes and heels. Dr. Pettine also reported the claimant reported "main complaints of severe ongoing back pain." Dr. Pettine recommended that the claimant not return to work as a truck drive because of "permanent physical impairments."

35. On December 18, 2008, Dr. F. Mark Paz, M.D., issued a report concerning an IME he performed on August 29, 2008. This IME was performed at the request of the MC respondents. Dr. Paz took the claimant's medical and employment histories and reviewed medical records dating back to March 2000. The claimant advised Dr. Paz that in the "many months" prior to January 31, 2007, his back ached, and that these symptoms were aggravated by activity with pain ranging as high as 8-9 on a scale of 10. These symptoms gradually intensified until the surgery in April 2008. The claimant explained that he elected to undergo surgery by Dr. Pettine because Dr. Pettine advised him there was a "probability" of improvement with surgery. However, the claimant told Dr. Paz that within several weeks of undergoing surgery in April 2008 his symptoms returned to the preoperative level. On the date of examination that claimant stated his low back pain rated 7-8 on a scale of 10, which was greater on the left than the right. The claimant also reported bilateral lower extremity pain.

36. In the report of December 18, 2008, Dr. Paz diagnosed the claimant as suffering from chronic, advanced degenerative disc disease (DDD) of the lumbar spine. Dr. Paz opined to a reasonable degree of medical probability that the lumbar DDD is the result of "aging and genetic factors" and cannot be causally connected to the claimant's "work related exposure." Dr. Paz opined that evidence the claimant also suffers from non-industrial DDD of the cervical spine and degenerative joint disease in both hips supports his opinion concerning the etiology of the lumbar DDD.

37. On February 3, 2009, Dr. Hughes performed a second IME at the claimant's request. The claimant gave a history that he had gradually worsened after the IME performed in August 2006 and developed a "new symptom" of pain radiating down the left leg. Dr. Hughes also reviewed medical records accumulated since the August 2006 IME, including the report of Dr. Paz.

38. In his report of February 9, 2009, Dr. Hughes reiterated his opinion that the claimant's prolonged exposure to sitting and jarring while working as a truck driver "accelerated his lumbar spine condition." Dr. Hughes further opined that this injurious exposure continued after the claimant began work at Arlo and this exposure resulted in the "progression of his left lateralizing disc protrusion at L4-5." Dr. Hughes stated that it "is well known that intervertebral disc pressures are at their greatest while in the seated position." Dr. Hughes noted that in August 2006 he had considered the L4-5 disc "protrusion" to represent an "incidental finding" because it did not correlate with the claimant's symptoms.

39. On March 8, 2009, Dr. Scott Primack, D.O., performed a medical records review. Dr. Primack opined that, based on review of all the records, "it is clear that [the claim-

ant's] work at Arlo Transportation continued to aggravate his back condition." Dr. Primack further stated that the claimant missed time from work at Arlo and this fact made "it clear that his work capacity caused a substantial permanent aggravation of his condition."

40. Dr. Hughes testified at the hearing held on June 29, 2009. Dr. Hughes opined the claimant is suffering from a "degenerative cascade" that began with the injury in 1982, but that this degenerative process was accelerated by an occupational disease caused by his duties as a truck driver for MC. Dr. Hughes also testified that after August 2006 the claimant suffered a "recrudescence of previously recorded left leg pain" that, according to the claimant's testimony, began about the time that he started work at Arlo. Dr. Hughes also opined that the claimant sustained a substantial permanent aggravation of his condition while working at Arlo. Specifically, Dr. Hughes opined the claimant's duties at Arlo were injurious, and that the Arlo employment made the claimant's condition worse. Dr. Hughes expressed agreement with the views of Dr. Primack. Dr. Hughes testified that he disagreed with Dr. Paz that the claimant's condition was the result of the progression of non-industrial DDD because Dr. Paz failed to "take into account the complex clinical course of two injuries treated surgically, followed then by degenerative disease at a new uninjured and unoperated level."

41. On cross-examination by counsel for the Arlo respondents, Dr. Hughes admitted that his opinions are significantly based on his judgment that the claimant's L4-5 disc pathology worsened after the August 2006 IME. However, Dr. Hughes conceded that the claimant reported some symptoms of a left-sided disc herniation at L4-5 prior to the August 2006 IME. These symptoms included the claimant's testimony that his left leg became "gimpy" and that on May 4, 2006, the claimant reported to Dr. Shaw that his left leg was "giving out." Dr. Hughes also admitted that a disc "extrusion" is the most serious form of a disc herniation, and therefore represents a more serious problem than a disc "protrusion." Dr. Hughes conceded that the December 2005 MRI reportedly showed a disc "extrusion" impinging on the L5 nerve root, and that the April 2007 MRI (taken after the claimant began work at Arlo in February 2007) was less serious because it showed a mere "protrusion" at L4-5 without impingement of the nerve root. Dr. Hughes stated that the April 2007 MRI appears to demonstrate that the disc material had been reabsorbed, and that such an occurrence is sometimes associated with improved symptoms. Dr. Hughes conceded that the April 2007 MRI appears to depict an improvement in the claimant's condition when compared to the December 2005 MRI.

42. At the hearing on June 29, 2009, the claimant testified that the surgery in April 2008 relieved his symptoms for a month or two. The claimant opined that he is unable to return to work as a truck driver because of his ongoing symptoms.

43. The claimant credibly testified that his back pain and left leg pain continued to worsen between April 2007 and April 2008. He stated that between these dates he could not "really do much of anything other than take myself, feed myself, and get up an go to work each day."

44. On August 24, 2009, Dr. Paz testified by post-hearing deposition. Dr. Paz was present for the claimant's testimony on June 29, 2009. Dr. Paz reviewed the MRI results from 2005 and 2007 and opined that the L4-5 disc protrusion was smaller in 2007 than 2005. He also opined the MRI results from 2005 and 2007 demonstrate degenerative changes at multiple levels. Based on the MRI results Dr. Paz testified that he could not

identify “advancement of the condition at a single level,” and that clinically he would expect the claimant to experience ongoing discomfort and become progressively worse. Dr. Paz reiterated his opinion that the changes shown on the MRI reflect degenerative changes attributable to age and heredity, not an industrial injury. In support of this opinion Dr. Paz stated that the MRI results demonstrate that the “foramens where the nerve roots exit at each level” appear “to have stenosis which is symmetric at each level.” Dr. Paz explained that evidence of such symmetry is not consistent with “acute or repetitive trauma.” Dr. Paz stated that he could not “establish that driving had any specific impact on his indications for surgery.” Moreover, Dr. Paz cited the existence of degenerative cervical disease and degenerative disease of the claimant’s hips as support for his theory that the claimant’s lumbar DDD results from a natural process unrelated to the claimant’s employment.

45. The ALJ finds it is more probably true than not that the claimant did not sustain an occupational disease proximately caused, aggravated or accelerated by the hazards of his employment as a truck driver at MC and/or Arlo. Dr. Paz credibly and persuasively opined that the claimant’s lumbar DDD is most probably caused by the natural progression of his age-related and congenital susceptibility to degenerative joint disease, and was not caused, aggravated or accelerated by the duties of his employment as a truck driver at MC and/or Arlo. Dr. Paz persuasively argues that the presence of DDD in the claimant’s cervical spine and the degenerative joint disease of hips demonstrate the claimant is susceptible to degenerative disease without regard to the alleged hazards of his employment. Indeed, in 2006 the claimant was required to undergo decompression surgery for his cervical DDD, and he does not assert that the need for this surgery was in any way caused, aggravated or accelerated by the duties of his employment at MC. Dr. Paz also reviewed the MRI results and found the evidence of stenosis to be inconsistent with traumatic injury or repetitive trauma. This explanation supports his opinion the lumbar DDD is not in any way connected to the claimant’s duties as a truck driver. The opinion of Dr. Paz that the claimant’s lumbar DDD is the result of the natural progression of his non-industrial DDD uninfluenced by the hazards of employment is corroborated by the credible opinions of Dr. Smaldone and Dr. Shaw.

46. The ALJ is not persuaded by the opinion of Dr. Hughes that the duties of the claimant’s employment contributed to a “degenerative cascade” by accelerating the progression of the claimant’s degenerative lumbar condition. The opinions of Dr. Hughes are to a significant degree based on his conclusion that the duties of the claimant’s employment accelerated the deterioration of the L4-5 disc after the IME conducted in August 2006. However, Dr. Hughes admitted that the 2005 MRI depicted a disc extrusion compressing the nerve root, which evidenced more serious pathology than was present on the April 2007 MRI *after* the claimant began working at Arlo. Moreover, Dr. Hughes conceded that the claimant demonstrated some symptoms of an L4-5 left-sided disc herniation before he performed the 2006 IME. The ALJ finds that this evidence tends to undermine the persuasiveness of the opinions expressed by Dr. Hughes.

47. The ALJ does not find the opinions of Dr. Primack to be persuasive with respect to the cause or causes of the claimant’s lumbar DDD. Dr. Primack’s opinion does not contain a detailed explanation of how it is supported by the medical evidence and principles of medical causation. The ALJ finds Dr. Primack’s opinions are not as persuasive or as well reasoned as the opinions expressed by Dr. Paz.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

PROOF OF AN OCCUPATIONAL DISEASE

The claimant contends that he proved that he sustained an occupational disease as a result of his employment at MC, and that he sustained a last injurious exposure and substantial permanent aggravation of the occupational disease while employed by Arlo. Therefore, the claimant asserts that the Arlo respondents are liable for indemnity benefits pursuant to § 8-41-304(1), C.R.S., and for medical benefits because the duties of the claimant's employment at Arlo caused the need for medical benefits after April 17, 2008.. *See Royal Globe Insurance Co. v. Collins,* 723 P.2d 731 (Colo. 1986); *University Park Care Center v. Industrial Claim Appeals Office,* 43 P.3d 637 (Colo. App. 2001). The MC respondents and the Arlo respondents argue the claimant has not proven that he sustained an occupational disease, and that the evidence establishes the claimant's condition is most probably the result of the natural progression of his non-industrial DDD. The ALJ agrees with the MC and Arlo respondents that the claimant did not prove that he sustained an occupational disease while employed by either of these employers. Rather the ALJ finds it is probably true that the claimant's lumbar DDD represents the natural progression of genetic and age-related DDD that was not caused, aggravated or accelerated by his employment.

Section 8-41-301(1)(c), C.R.S. provides that the right to recover benefits is conditioned on proof that the alleged injury was "proximately caused by an injury or occupational disease arising out of and in the course of the employee's employment and is not intentionally self-inflicted." Thus, in order to recover any benefits the claimant is required to prove that he sustained an occupational disease as defined by Act. In contrast, the provisions of § 8-41-304(1) govern liability for indemnity benefits in occupational disease cases where the existence of an occupational disease has been proven, but more than one insurer or employer is potentially liable for the disease. *See Robbins Flower Shop v. Cinea,* 894 P.2d 63 (Colo. App. 1995). Indeed, § 8-41-304(1) provides that it is applicable "when compensation is payable for an occupational disease."

The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time, place, and cause. *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993). An "occupational disease" is defined by §8-40-201(14), C.R.S., as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

This section imposes additional proof requirements beyond those required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* Indeed, a separately compensable occupational disease may be found where the ALJ determines that the hazards of a claimant's employment have aggravated or accelerated a medical condition caused in part by a prior industrial injury. *See University Park Care Center v. Industrial Claim Appeals Office, supra*. However, a claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Anderson v. Brinkhoff*, *supra.* Once the claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

The claimant was required to prove by a preponderance of the evidence that the alleged occupational disease was directly and proximately caused by the employment or working conditions. The question of whether the claimant met the burden of proof is

one of fact for determination by the ALJ. *Wal-Mart Stores, Inc. v. Industrial Claims Office,* 989 P.2d 251 (Colo. App. 1999).

As determined Findings of Fact 45 through 47, the ALJ concludes the credible and persuasive evidence establishes the claimant's lumbar DDD was not caused, aggravated or accelerated by the duties of his employment at MC or Arlo. Rather, the credible evidence, especially the persuasive and well-reasoned opinions expressed by Dr. Paz, establish that it is most likely that the claimant's lumbar DDD and ongoing symptoms are the result of the natural progression of genetic and age-related DDD that has not been aggravated or accelerated by the claimant's duties as a truck driver at MC and Arlo. Thus, ALJ concludes the claimant failed to prove that he sustained any occupational disease caused, aggravated or accelerated by the duties of his employment at either MC or Arlo.

This conclusion requires that WC 4-760-753, the claim against the Arlo respondents, be denied and dismissed. Because the claimant failed to prove that he has sustained any occupational disease no indemnity or medical benefits are payable to the claimant because of his employment at Arlo. Section 8-41-301(1)(c). Since the claimant failed to prove that he sustained an occupational disease the ALJ need not consider the parties' arguments concerning that applicability of § 8-41-304(1), or whether MC or Arlo was "on the risk" for purposes of determining liability for medical benefits.

WHETHER THE DOCTRINES OF CLAIM CLOSURE OR ISSUE PRECLUSION PREVENT THE ALJ FROM CONSIDERING THE ISSUE OF "COMPENSABILITY" WITH RESPECT TO THE MC RESPONDENTS

The claimant contends that, regardless of the ALJ's determination that the claimant failed to prove a compensable occupational disease with respect to the Arlo respondents, ALJ Jones has already determined that he sustained a compensable occupational disease while employed by MC. In this situation the claimant asserts the MC respondents are bound by the order of ALJ Jones and may not relitigate the question of whether he sustained a compensable occupational disease. Specifically, the claimant reasons that the order entered by ALJ Jones "closed" the issue of compensability and the MC respondents may not seek any reconsideration of that issue without filing a petition to reopen. The MC respondents further assert that the doctrine of issue preclusion prohibits the MC respondents from relitigating the issue of compensability. The ALJ disagrees with the claimant's arguments.

First, the ALJ concludes that the order of ALJ Jones did not constitute an "award" that "closed" the issue of compensability in WC 4-698-452, such that the MC respondents were required to file a petition to reopen in order to dispute the existence of a compensable occupational disease when challenging the claimant's request for additional medical and temporary disability benefits. Rather, ALJ Jones reserved for future determination "all matters" not determined in her order. Thus, although the order of ALJ Jones may have determined the claimant sustained a compensable occupational disease that entitled him to limited medical benefits, and the "award" of these limited medical benefits may have become final by the exhaustion of administrative review proceed-

ings, the order did not constitute an "award" sufficient to close the entire claim. Rather, the insertion of the reservation clause demonstrates that the order was not intended to close the claim and prohibit the respondents from contesting compensability without filing a petition to reopen in the event the claimant sought additional benefits. *See Brown and Root, Inc. v. Industrial Claim Appeals Office,* 833 P.2d 780 (Colo. App. 1991). The ALJ does not understand the MC respondents as challenging or seeking to "reopen" the limited award made by ALJ Jones, but instead they seek to dispute liability for the additional benefits that the claimant now seeks as a result of the alleged occupational disease.

However, the mere fact that the order of ALJ Jones did not close the claim so as to require a petition to reopen does not resolve the separate question of whether the doctrine of "issue preclusion" forecloses the MC respondents from disputing whether or not the claimant proved a compensable occupational disease. The doctrine of issue preclusion applies in workers' compensation proceedings. *Feeley v. Industrial Claim Appeals Office,* 195 P.3d 1154 (Colo. App. 2008). The elements of issue preclusion are: "(1) the issue sought to be precluded is identical to an issue actually determined in the prior proceeding; (2) the party against whom estoppel is asserted has been a party to or is in privity with a party to the prior proceeding; (3) there is a final judgment on the merits in the prior proceeding; and (4) the party against whom the doctrine is asserted had a full and fair opportunity to litigate the issue in the prior proceeding." *Sunny Acres Villa, Inc. v. Cooper,* 25 P.3d 44 (Colo. App. 2001).

Here, the ALJ concludes the first three elements of "issue preclusion" have been satisfied. First, the issue decided by ALJ Jones, whether the claimant's employment at MC aggravated or accelerated the degenerative disease process so as to cause a compensable occupational disease, is the same issue decided in this case. Second, the MC respondents were parties to the prior proceeding. Third, the record establishes that the findings of ALJ Jones have become final after the exhaustion of appellate remedies.

However, the ALJ concludes the element of a "full and fair opportunity" to litigate in the prior proceeding has not been satisfied. In *Sunny Acres Villa, Inc. v. Cooper, supra,* the court stated that this element requires "not only the availability of procedures in the earlier proceeding commensurate with those in the subsequent proceeding [citation omitted], but also that the party against whom collateral estoppel is asserted have had the same incentive to vigorously defend itself in the previous action." 25 P.3d at 47. The *Sunny Acres Villa* court stated that a party necessarily lacks the incentive to defend itself if its exposure to financial liability is substantially less in the prior proceeding, or if there are significant variations in exposure resulting from differences in the finality or permanence of the judgments. 25 P.3d at 47. Hence, in *Sunny Acres Villa, Inc. v. Cooper, supra,* the court held that respondents were not precluded from relitigating the cause of the claimant's psychiatric condition where the first hearing and order concerned liability for temporary disability benefits, but the second hearing and order concerned permanent total disability. *See also, Mattox v. Hub Distributing, Inc.* WC No. 4-471-963 (ICAO November 7, 2005); *Landolt v. Scott Specialty Gases, Inc.,* WC No. 4-130-484 (ICAO November 5, 2001).

Here, the ALJ concludes that the MC respondents did not have the same incentive to litigate the issue of whether the claimant sustained an occupational disease in the proceeding before ALJ Jones as they had in this proceeding. Although the ALJ cannot ascertain the exact dollar value of the medical benefits at stake before ALJ Jones, it is clear that the issue was limited to liability for a consultation with Dr. Smaldone and treatment rendered by Dr. Castro and Dr. Hemler *after* November 16, 2006. In these circumstances the ALJ infers the total amount at stake before ALJ Jones was not great, especially since it appears that most of the treatment provided to the claimant by Dr. Castro and Dr. Hemler occurred *before* November 16, 2006.

In contrast, the issues for determination in this case include not only liability for medical benefits commencing April 17, 2008, but also liability for temporary total disability (TTD) benefits commencing April 1, 2008, and continuing until terminated in accordance with law. As may be inferred from the claimant's testimony that he is unable to return to work, as well as the opinions of various physicians that the claimant should not return to work as a truck driver, the ALJ concludes the MC respondents risk substantially greater exposure in this proceeding than they did when litigating the issue of limited medical benefits before ALJ Jones. Indeed, if the MC respondents are found liable for TTD benefits in this proceeding the total amount of their exposure would be unknowable since termination of TTD benefits usually depends on the future occurrence of one of the events described in § 8-43-105(3), C.R.S. Further, if TTD were terminated based on a finding of MMI by an authorized treating physician, that determination would not necessarily be determinative if the finding were challenged through a Division-sponsored independent medical examination. Section 8-42-107(8)(b)(II) & (III), C.R.S.

In these circumstances, the ALJ concludes that in the proceeding before ALJ Jones the MC respondents did not have a "full and fair opportunity" to litigate the issue of whether or not the claimant sustained an occupational disease caused, aggravated or accelerated by the alleged hazards of his employment with MC. Therefore, the doctrine of issue preclusion does not bar the ALJ from considering whether or not the claimant proved that she sustained a compensable occupational disease while employed at MC. Because, the ALJ has found that the claimant did not sustain an occupational disease while employed by MC, the claim for additional medical and temporary disability benefits in WC 4-698-452 must be denied and dismissed.

In light of these determinations the ALJ need not address the other issues raised by the parties.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The claim for benefits in WC 4-760-753 is denied and dismissed.

2. The claim for additional benefits in WC 4-698-452 is denied and dismissed.

DATED: October 1, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-752-313

ISSUE

The sole issue to be determined by this decision concerns post-maximum medical improvement (MMI) maintenance medical benefits, also know as *Grover* medical benefits. Claimant bears the burden of proof, by a preponderance of the evidence.

FINDINGS OF FACT

1. Respondent initially filed a Final Admission of Liability on July 1, 2008, denying *Grover* medical benefits and admitting to the zero permanent medical impairment pursuant to the rating given by Annu Ramaswamy, M.D., in his report of June 3, 2008. Respondent filed a subsequent Final Admission of Liability on June 1, 2009, admitting to the 11% impairment rating of Douglas E. Hemler, M.D., the Division Independent Medical Examiner (DIME), pursuant to the Order of ALJ Laura Broniak of May 8, 2009. The Claimant objected to the Final Admission of Liability of June 1, 2009 because it denied medical benefits after MMI and the present request for hearting followed.

2. The parties stipulated and the ALJ finds that the Claimant desires to have medical care from David Reinhard, M.D. The Claimant stated that she would now be open to injection therapy if prescribed by Dr. Reinhard. She saw Dr. Reinhard in July 2009 for care. Dr. Ramaswamy and Dr. Reinhard were authorized treating physicians (ATPs). The Claimant reached maximum medical improvement (MMI) on June 3, 2008, according to Dr. Ramaswamy's report of June 3, 2008.

3. in his October 7, 2008 DIME report, Dr. Hemler concurred with the June 3, 2008 date of MMI.

4. The June 3, 2008 report of Dr. Ramaswamy states: "Maintenance: I am recommending 12 visits over 6 months with Dr. Eldridge and Dr. Reinhard as needed. She [Claimant] should keep up with all of her home exercises. She is discharged from my care at this point but, once again, has maintenance treatments for up to 6 months post-MMI."

5. The November 21, 2008 report of Dr. Ramaswamy states: "When I released her at MMI, she was independent with all of her activities and was functioning quite well. This is another reason that I feel [Claimant] is not **deserving** (emphasis sup-

plied) of permanency at this time." The ALJ finds this conclusion confusing because the ALJ cannot ascertain whether a moral or a medical judgment is expressed.

6. The October 7, 2008 report of Dr. Hemler states: "The current treatment plan is appropriate including occasional manipulation and injection. Dr. Reinhard has apparently considered the possibility of facet injections. The patient indicates she is really not anxious to proceed with any of these treatments. At the conclusion of approximate 6 months I anticipate she will be ready for self-management. She does report that there is some pain control from the ongoing treatments. In this regard I would recommend 4-8 chiropractic sessions from December 2009 [–] June 2009 if these are considered necessary." In her testimony at hearing, the Claimant stated that she is now ready for any treatment recommended by Dr. Reinhard.

7. Dr. Reinhard's report of July 17, 2008 states: "There is hypertonia, although generally the muscles are more supple in the left posterior cervical and suboccipital area, as well as the left suprascapular region. Some trigger points are identified in the left cervical paraspinals, splenius capitis, upper trapezius and levator scapula. She has hypersensitivity over the occipital nerves on the left." Additionally, in his December 2, 2008 report Dr. Reinhard notes: "On examination, she is much more supple in the left posterior cervical and suprascapular musculature though still has tenderness in some myofascial bands and trigger points most notable in the left longissimus and splenius capitis. She has restricted cervical rotation to the left. She is pleasant and relational with a normal range of affect." During a February 24, 2009 visit, Dr. Reinhard stated: "[Claimant] is maintaining MMI status. She has had a bit of a setback with the recent pain exacerbation in the left posterior cervical and suprascapular region, as well as along the right medial scapular [border]. I am going to have her go back on the Lodine 400 mg b.i.d. and carisoprodol 1 t.i.d. p.r.n. spasm until things quiet down back to baseline. If that is not happening, then she will follow up with me sooner than a scheduled follow up appointment in two months. She can continue with the Vicodin ES as she has been using it."

8. Any findings of DIMf Dr. Hemler with respect to *Grover* medical treatment are on the level playing field of "preponderance of the evidence."

9. The ALJ finds the opinions of Dr. Hemler and Dr. Reinhard more persuasive than those of Dr. Ramaswamy. Dr. Reinhard continued to detect muscle spasms and trigger points after MMI. The opinions of Dr. Ramaswamy in his November 21, 2008 report are not based on a physical examination of the Claimant, only a paper review. Additionally, Dr. Ramaswamy's judgment that the Claimant is not "deserving" of permanency is contradicted by Respondent's latest Final Admission, and it manifests a "moral" bias that further undermines his credibility. Dr. Reinhard continued to prescribe medication for the Claimant as noted in the February 24, 2009 report. The Claimant needs ongoing oversight of her prescription management.

10. The Claimant has proven, by a preponderance of the evidence that post-MMI medical maintenance care is causally related to the original admitted injury, and it

is reasonably necessary to maintain the Claimant at MMI and to prevent a deterioration of her work-related condition. The need for post-MMI medical maintenance treatment is supported by substantial evidence in the record.

11. Dr. Reinhard was within the authorized chain of referrals.

12. Because of some vagaries in Dr. Reinhard's latest reports, continued treatment under his auspices should be contingent upon Dr. Reinhard promptly filing a "Treatment Plan" with the Division of Workers' Compensation, copy to Respondent, clearly and specifically stating the causal relationship between continued post-MMI maintenance treatment and the admitted injury; and, more specifically outlining what treatment will be provided.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

1. The *Grover* case established the test for medical benefits past the date of MMI. There must be substantial evidence in the record to support a determination that future medical treatment will be reasonably necessary to relieve the injured worker from the effects of the work-related injury or occupational disease. *Grover v. Industrial Commission of Colorado*, 759 P.2d 705 (Colo.1988). As found, there was substantial evidence in the record supporting post-MMI medical maintenance treatment.

2. An ALJ's factual findings must be supported by substantial evidence in the record. *Brownson-Rausin v. Industrial Claim Appeals Office,* 131 P.3d 1172 (Colo. App. 2005). Substantial evidence is "that quantum of probative evidence which a rational fact-finder would accept as adequate to support a conclusion, without regard to the existence of conflicting evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995). As found, the need for post-MMI medical maintenance benefits is supported by substantial evidence in the record.

3. To be authorized, all referrals must remain within the chain of authorized referrals in the normal progression of authorized treatment. *See Mason Jar Restaurant v. Industrial Claim Appeals Office,* 862 P. 2d 1026 (Colo. App. 1993); *One Hour Cleaners v. Industrial Claim Appeals Office,* 914 P. 2d 501 (Colo. App. 1995); *City of Durango v. Dunagan,* 939 P.2d 496 (Colo. App. 1997). As found, Dr. Reinhard was within the authorized chain of referrals.

4. *Grover* medical benefits are subject to the same tests of causal relatedness and reasonable necessity to which pre-MMI medical benefits are subject. Medical care and treatment must be causally related to an industrial injury or occupational disease. *Dependable Cleaners v. Vasquez,* 883 P.2d 583 (Colo. App. 1994). As found, Claimant's need for pos-MMI medical maintenance care medical is causally related to her admitted, compensable injury of February 14, 2008. Also, medical treatment must be reasonably

necessary to cure and relieve the effects of the industrial occupational disease. § 8-42-101 (1) (a), C.R.S. (2009). *Morey Mercantile v. Flynt,* 97 Colo. 163, 47 P. 2d 864 (1935); *Sims v. Industrial Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). As found, all of the Claimant's recommended post-MMI medical maintenance care and treatment, as reflected in the evidence, is reasonably necessary to maintain her at MMI.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondent shall pay the costs of post maximum medical improvement medical maintenance care, as prescribed by Dr. Reinhard and his authorized referrals, contingent upon Dr. Reinhard filing a Medical Treatment Plan, specifically detailing the causal connection between his treatment and the admitted compensable injury herein, and detailing what specific treatments he will provide, with the Division of Workers' Compensation (DOWC), copy provided to the Respondent, subject to the DOWC Medical Fee Schedule.

B. Any and all issues not determined herein are reserved for future decision.

DATED this 2 day of October 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-760-857

ISSUES

Whether Claimant is entitled to Temporary Total Disability benefits beginning June 9, 2008, and continuing.

If Claimant is not entitled to Temporary Total Disability benefits beginning June 9, 2008, whether Respondent may claim the Temporary Total Disability benefits paid from June 9, 2008, through April 2, 2009, as a credit against future benefits.

Whether C.R.S. Section 8-42-105(3)(c) violates Claimant's fundamental due process rights.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant sustained an admitted industrial injury on March 23, 2007, when he was struck in the head by a tool belt dropped by a contractor working in the ceiling at Employer. Employer referred Claimant to Arbor Occupational Medicine, where he was first seen on March 27, 2007, and released to return to work full duty by Dr. Jim Rafferty, D.O. Claimant has continued under the care of the physicians at Arbor Occupational Medicine. Beginning July 12, 2007, Claimant came under the care of Bruce B. Cazden, M.D. at Arbor Occupational Medicine.

2. At his initial examination of Claimant on July 12, 2007 Dr. Cazden noted that Claimant had had coronary artery surgery on May 31, 2007 and had poor energy Dr. Cazden noted that Claimant complained of mild blurriness of vision but did not complain of headache or confusion. Dr. Cazden diagnosed CHI (closed head injury) and blurry vision. Dr. Cazden did not address Claimant's work status or need for restrictions. At the time of this visit, Claimant was continuing to work his regular job at Employer.

3. Claimant was employed as a principal parts engineer at Employer. Claimant worked on development of electronic components for satellite and aerospace applications. Claimant was a Level 5 engineer, the second highest level at Employer. Claimant's job involved highly specialized engineering tasks unique to space applications. Claimant has 25 years experience in the space and aerospace industry.

4. Following the admitted injury on March 23, 2007 Claimant continued to work at Employer until June 9, 2008. On that date, Claimant was placed on unpaid furlough and subsequently laid-off from his job with Employer. Claimant has not returned to work since June 9, 2008.

5. On September 27, 2007, Dr. Cazden referred Claimant for a brain trauma evaluation and Claimant was seen by James P. Kelly, M.D. on October 30, 2007. Claimant saw Dr. Kelly for a recheck visit on December 3, 2007. Dr. Kelly noted Claimant's complaints that he felt like he was struggling in his work performance, forgetting things easily and requiring notes to remind himself of meetings and other job-related functions. Dr. Kelly did not make any recommendations on the need for work restrictions. Dr. Kelly recommended medications and scheduled a follow-up visit in one month

6. Dr. Cazden evaluated Claimant on December 10, 2007 and specifically noted that Claimant had been seen by Dr. Kelly on December 3, 2007 and that Dr. Kelly had recommended medications and set a follow up visit. Dr. Cazden released Claimant to return to work full duty.

7. Dr. Cazden evaluated Claimant on January 22, 2008. Dr. Cazden noted that Claimant had been seen by Dr. Kelly who had recommended therapy of memory issues. Dr. Cazden obtained a history that Claimant had been performing work tasks without any obvious problems but did complain of problems with short-term memory. Dr. Cazden

stated he was awaiting recommendations from Dr. Kelly for therapy. Dr. Cazden released Claimant to return to work full duty.

8. Dr. Cazden referred Claimant to Mary Ann Keatley, Ph.D., a speech-language pathologist and certified neurotherapist. Dr. Cazden reviewed Dr. Keatley's treatment notes as they were provided to him and spoke to Dr. Keatley a number of times during his treatment of Claimant.

9. Dr. Keatley saw Claimant on May 12, 2008 and noted that Claimant felt "overloaded at work" and was working on weekends to keep up with work demands. Dr. Keatley did not address any need for work restrictions. At a follow up visit on May 19, 2008 Dr. Keatley noted that Claimant demonstrated continued progress with short-term memory.

10. Dr. Cazden evaluated Claimant on May 15, 2008. Dr. Cazden had spoken with Dr. Keatley and reviewed her reports. Dr. Cazden noted Claimant's complaints to Dr. Keatley of daily fatigue and that Claimant felt he was not able to do his work tasks as he used to. Dr. Cazden called Joe Winslow at Employer to discuss Claimant's work. Dr. Cazden stated, and it is found, that from a cognitive standpoint Claimant was tolerating work and no deficits in the workplace had been noted based upon the information supplied to Dr. Cazden by Mr. Winslow at Employer.

11. Dr. Keatley evaluated Claimant on June 5, 2008 and noted complaints of persisting cognitive fatigue and that Claimant was working extra hours to keep up with work deadlines. Dr. Keatley stated, and it is found, that Claimant was improving slowly but steadily. Dr. Keatley recommended a neuropsychological evaluation to assist in developing a further treatment plan. Dr. Keatley did not address the need for work restrictions.

12. Dr. Keatley evaluated Claimant on June 9, 2008 and again noted complaints of extreme fatigue and that Claimant complained of having great difficulty at work. Dr. Keatley further noted that Claimant's ability to use multi-track thinking was steadily improving but continued to be a challenging area. Dr. Keatley did not address the need for any work restrictions. Dr. Keatley again evaluated Claimant on June 16, 2008 and noted Claimant had been placed on furlough indefinitely from his job. Dr. Keatley's assessment was that Claimant was improving steadily but that comprehending logic tasks was still challenging. Dr. Keatley did not address the need for work restrictions or the issue of Claimant being unable to continue performing his work for Employer.

13. Claimant saw Dr. Cazden for follow up on June 19, 2008. Dr. Cazden noted that Claimant had been laid off on June 9, 2008. Dr. Cazden had spoken with Dr. Keatley who stated to Dr. Cazden that Claimant had continued to make progress with increasingly difficult puzzles and was nearly ready to advance to Level IV in therapy. Dr. Cazden recommended a follow up neuropsychological evaluation with Dr. Kelly or another neuropsychologist if Dr. Kelly was unavailable. Dr. Cazden released Claimant to return to work full duty.

14. Dr. Cazden evaluated Claimant on July 3, 2008 and stated in his office note that Claimant had been furloughed due to slowdown in business. Claimant told Dr. Cazden that he felt like he was still making great strides in cognitive therapy. Dr. Cazden released Claimant to return to work full duty. Dr. Cazden has continually released Claimant to return to work full duty at subsequent evaluations through August 28, 2009.

15. On November 14, 2008, Claimant's attorney sent the claim adjuster a letter which stated in pertinent part: "*As a result of Mr. Turner's work-related brain injury, he was furloughed from Ball Aerospace on June 9, 2008, and formally laid off on September 6, 2008. I believe that Mr. Turner is entitled to temporary total disability benefits beginning June 9, 2008, and ongoing*." Claimant's attorney's letter did not make mention of the fact that Claimant had been continually released by Dr. Cazden to return to work full duty. On November 20, 2008, Respondent filed a General Admission of Liability for temporary total disability benefits beginning June 9, 2008, to unknown, with the statement "*Liability accepted for closed head injury only*". Respondent later filed a General Admission of Liability terminating benefits on April 9, 2009, based on a full-duty release from Dr. Cazden.

16. In a "To Whom it May Concern:" report of April 10, 2009 Dr. Keatley stated that Claimant is not currently able to return to work resuming his pre-injury duties in his job due to his persisting cognitive deficits.

17. In a July 30, 2009 letter to Claimant's counsel Dr. Keatley responded to a request from Claimant's counsel for a set of work restrictions for Claimant. Dr. Keatley stated work restrictions of a shorter workday, frequent rest breaks, work in a quiet environment, work at a single location and consistent supervision to monitor and ensure errors are corrected. Dr. Keatley stated that Claimant should not supervise other employees or carry out long conversations about complex information. Dr. Keatley opined that these restrictions were retroactive to June 8, 2008. The ALJ finds Dr. Keatley's retroactive and retrospective assignment of work restrictions to Claimant to be unpersuasive.

18. In a letter in response to a letter from Claimant's counsel dated July 31, 2009 Dr. Kelly issued a letter report dated August 13, 2009 agreeing with the recommendations for work restrictions and accommodations stated by Dr. Keatley. Dr. Kelly issued a report dated January 23, 2009 stating his opinion that Claimant's current cognitive abilities were unlikely to allow him to return even part time to the line of work as an engineer he had previously. In a report from a prior visit on November 5, 2008 Dr. Kelly noted gradual improvement in Claimant's abilities according to the notes from Dr. Keatley. Dr. Kelly recommended further care for visual perceptual deficits and continued therapy with Dr. Keatley. Dr. Kelly made no mention of a worsening cognitive condition in either his November 5, 2008 or January 13, 2009 reports to provide a persuasive basis for his restriction on Claimant's work. Dr. Kelly's opinions concerning Claimant's ability to work are not persuasive.

19. At the time Claimant was laid off he remained on full duty status form Dr. Cazden as Dr. Cazden's investigation of Claimant's condition did not show a reason not to have Claimant on full duty. At this time, Dr. Cazden had not been provided with any information from Dr. Kelly or from Dr. Keatley that Claimant should have been on work restrictions although Dr. Cazden acknowledges that it is possible some work accommodations may have been required but not that Claimant should have been out of work.

20. Dr. Cazden opined, and it is found, that returning Claimant to work was not causing damage or was a detriment to Claimant from a cognitive standpoint.

21. The ALJ finds that while Dr. Kelly is an authorized and attending physician, he was not "the attending physician" for Claimant's March 23, 2007 injury. Dr. Cazden was the attending physician who exercised the primary control over Claimant's treatment and the determination of Claimant's ability to return to work and Dr. Cazden is "the attending physician" for purposes of Claimant's March 23, 2007 injury.

22. Dr. Keatley is a "non-physician provider" as defined by WCRP 16-5(A)(1)(b)(11) and (16).

23. Respondent's admission for and payment of TTD benefits beginning June 9, 2008 was an error. Claimant was not entitled to TTD benefits from June 9, 2008 through April 3, 2009 as admitted by Respondent because during the period the Claimant had been continuously released to return to work full duty by the attending physician, Dr. Cazden.

24. Respondent's payment of TTD benefits to Claimant for the period from June 9, 2008 through April 3, 2009 was an overpayment as it was money received by Claimant which Claimant was not entitled to receive. Claimant has failed to prove an entitlement to TTD benefits beginning June 9, 2008 and continuing.

CONCLUSIONS OF LAW

25. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

26. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

27. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

28. Pursuant to Sections 8-42-103 and 8-42-105, C.R.S. a claimant is entitled to an award of TTD benefits if: (1) the injury or occupational disease causes disability; (2) the injured employee leaves work as a result of the injury; and (3) the temporary disability is total and lasts more than three regular working days. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542, 546 (Colo.1995). If the claimant proves these threshold criteria, temporary total disability benefits continue until the occurrence of one of the four terminating events specified in § 8-42-105(3). *Id.* However, Section 8-42-105(3)(c) provides that temporary total disability benefits shall continue until "[t]he attending physician gives the employee a written release to return to regular employment."

29. Section 8-42-105(3)(c) provides that temporary total disability benefits cease when the attending physician gives the employee a release to regular employment. The attending physician's opinion concerning the Claimant's ability to return to regular employment is binding on the parties. *Burns v. Robinson Dairy, Inc.*, 911 P2d. 661 (Colo. App. 1995). In *Burns,* the Court of Appeals held that the opinion of the attending physician binds an ALJ with respect to the Claimant's ability to perform regular employment. Although there may be more than one attending physician not all attending physicians are "the attending physician". The term "the attending physician" connotes the physician with primary control over the Claimant's treatment, not merely the provision of some authorized treatment. See, *Popke v. Indus. Claim Appeals Office,* 944 P.2d 677, 680-681 (Colo. App. 1997); *Witherspoon v. Metropolitan Club of Denver,* W.C. No. 4-509-612 (December 16, 2004).

30. The ALJ retains fact finding authority where multiple attending physicians offer conflicting opinions concerning the Claimant's ability to return to regular employment. Where there are no conflicting opinions from physicians regarding Claimant's release to work, the ALJ is not at liberty to disregard the attending physician's opinion that Claimant is released to return to employment. *Burns,* supra. If there is a conflict in the record regarding Claimant's release to return to regular employment, the ALJ must resolve the conflict. *Imperial Headware, Inc. v. Indus. Claim Appeals Office,* 15 P.3d 295 (Colo. App. 2000). If the record contains conflicting opinions from multiple attending physicians concerning Claimant's ability to perform regular employment, the ALJ resolves the conflict as a matter of fact. *Bestway Concrete v. Indus. Claim Appeals Office,* 984 P.2d 680 (Colo. App. 1999).

The attending physician's determination of Claimant's ability to perform regular work is dispositive and Claimant's subjective assessment of his physical limitations is legally immaterial. *Bestway Concrete,* supra.

31. As found, Dr. Cazden was "the attending physician" for Claimant's March 23, 2007 work injury. At the time Claimant was laid off on June 9, 2008 there were no conflicting opinions concerning Claimant's ability to perform his regular work as an engineer for Respondent. Neither Dr. Kelly nor Dr. Keatley addressed the issue of work restrictions until well after Claimant had left work due to his lay off from Employer. Dr. Cazden's opinions concerning Claimant's ability to perform regular work are without conflict. While Dr. Cazden acknowledges that some accommodations may have been appropriate for Claimant, that acknowledgement did not alter Dr. Cazden's ultimate opinion that Claimant remained capable to perform his regular work and that continuing to perform this work was neither causing damage nor was detrimental to Claimant's recovery. In fact, despite Claimant's increasing complaints of difficulty with work performance, his attending physicians, including Dr. Keatley, continually reported that Claimant's cognitive status was improving. Because the attending physician, Dr. Cazden, in June 2008 maintained Claimant's status of being released to return to full duty and there were no conflicting opinions from other attending physicians the ALJ is bound by Dr. Cazden's opinion concerning Claimant's entitlement to TTD benefits beginning June 9, 2008.

32. As to the later opinions obtained from Dr. Keatley and Dr. Kelly regarding Claimant's ability to work, the ALJ resolves the conflict between these opinions and the opinions and reports of Dr. Cazden continuing to release Claimant to return to work full duty in favor of the opinions of Dr. Cazden. Further, the opinions of Dr. Keatley are not opinions of an attending physician as Dr. Keatley is a "non-physician provider" as defined by the WCRP. As noted by Dr. Cazden during his deposition, both the opinions of Dr. Kelly and Dr. Keatley conflict with their earlier statements regarding the status and progress of Claimant's cognitive condition. The ALJ is not persuaded by Dr. Kelly's and Dr. Keatley's retrospective assessment of Claimant's work ability obtained upon request of Claimant's counsel after TTD benefits had been terminated based upon the continued release of Claimant to return to full duty work by Dr. Cazden, "the attending physician". As such, Respondent appropriately terminated the payment of TTD benefits to Claimant effective April 3, 2009 under Section 8-42-105(3)(c), C.R.S.

33. As provided by Section 8-40-201(15.5), C.R.S. "overpayment" means:

> "money received by a claimant that exceeds the amount that should have been paid, or which the claimant was not entitled to receive, or which results in duplicate benefits because of offsets that reduce disability or death benefits payable under said articles. For an overpayment to result, it is not necessary that the overpayment exist a the time the claimant received disability or death benefits under said articles."

Under Section 8-43-207(1)(q), C.R.S. the ALJ is empowered to require repayment of overpayments.

34. As found, Respondent's payment of TTD benefits to Claimant for the period from June 9, 2008 through April 3, 2009 was in error and amounted to an overpayment to Claimant. As found and concluded Claimant was not entitled to TTD benefits during this period. Respondent may recover this overpayment by crediting the amount paid against any future awards of compensation benefits to Claimant.

35. At hearing, Claimant raised an issue concerning the constitutionality of Section 8-42-105(3)(c), C.R.S. contending that the operation of that Section violates Claimant's fundamental due process rights. Administrative law courts do not have jurisdiction to rule on facial constitutional challenges. *Kinterknecht v. ICAO*, 175 Colo. 60, 485 P2d. 721 (1971). Accordingly, the Judge does not address or resolve this issue although it was raised on the record and preserved for future appeal.

ORDER

It is therefore ordered that:

1. Claimant's claim for Temporary Total Disability benefits from June 9, 2008, and continuing is denied and dismissed.

2. Respondent shall be entitled to credit the overpayment of Temporary Total Disability benefits from June 9, 2008, against any future award of benefits to Claimant.

3. All matters not determined herein are reserved for future determination.

DATED: October 2, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-608-267

ISSUES

The issues to be determined by this decision concern Respondents request for a ruling under C.R.C.P., Rule 57, allegedly applicable by virtue of OACRP, Rule 2, regarding whether Respondents may file a Final Admission of Liability (FAL), based on the opinions of Dr. Anderson-Oeser, an ATP who formed her opinions, based on an examination of Claimant and review of medical records after ALJ Morgan Rumler had reopened Claimant's case because of a worsening of condition. Counsel for Respondents

verbally represented, at the commencement of the September 15 proceedings, that it sought a "declaratory" order because of the specter of a bad faith lawsuit. The mere fact that Respondents sought a declaratory judgment, instead of filing an FAL, based on Dr. Anerson-Oeser's opinion after ALJ Rumler had reopened Claimant's case because of a worsening of condition evidences a degree of good faith. In response, Claimant endorsed the issues of ripeness and issue preclusion. Claimant also requests attorney fees against the Respondents for alleged lack of "ripeness" of the issues set for hearing. The issues concern the parties' respective legal rights and responsibilities with regard to the opinion of Dr. Anderson-Oeser on the issues of maximum medical improvement (MMI) and permanent impairment.

Respondents assert that Dr. Anderson-Oeser's opinions would support an FAL, pursuant to § 8-42-107, C.R.S. (2009). Claimant asserts that a consideration of the issues is barred by the doctrine of issue preclusion and the law of the case previously established by ALJ Morgan Rumler, and not ripe for adjudication, thus, entitling an award of attorney fees against the Respondents (an affirmative proposition for which Claimant bears the burden of proof by a preponderance of the evidence). Dr. Anderson-Oeser's opinion as a result of re-examining the Claimant in August 2008, re-affirmed her pre-reopening opinion that Claimant had reached MMI in 2004 before the worsening of condition. This opinion would nullify, and render meaningless, ALJ Rumler's decision, dated March 10, 2008, which held that Claimant's condition had worsened and Claimant was no longer at MMI, thus, amounting to a "doctor nullification" of the law of the case, *i.e.,* that Claimant was **no longer** at MMI. Respondents contend that a controversy exists as to the parties' rights and obligations under the Colorado Workers' Compensation Act. Respondents assert that there is no genuine issue of material fact in that the Respondents are entitled to a judgment and/or declaratory relief, as a matter of law. ALJ Ted Krumreich previously denied Respondents' Motion for Summary Judgment on July 29, 2009, and the matter is now postured on Respondents' Motion for a declaratory Judgment.

FINDINGS OF FACT

Based on the evidence contained in the record, the ALJ makes the following Findings of Fact:

1. The Claimant suffered an admitted work-related injury on October 3, 2003. She worked for the Employer processing checks. She was diagnosed with a repetitive motion injury to her left upper extremity.

2. Martin Kalevik, D.O., initially treated Claimant. On March 5, 2004, Dr. Kalevik noted ongoing symptoms and placed Claimant at MMI. He provided work restrictions and noted that Claimant might need to change the type of work she was doing. On March 16, 2004, Respondents filed a Final Admission of Liability, based on Dr. Kalevik's

MMI date of March 5, 2004 and his scheduled rating of 10% of the left upper extremity (LUE).

3. Claimant continued to work for the Employer. Her position changed and she was required to lift -- in addition to her previous repetitive work. Her condition worsened.

4. From January 4, 2004 to January 11, 2005, Claimant continued to treat with Dr. Kalevik. He referred Claimant for a one-time evaluation with Dr. Anderson-Oeser. Claimant saw Dr. Anderson-Oeser for a one-time evaluation on January 28, 2005. As a result of this evaluation, Dr. Anderson-Oeser agreed with Dr. Kalevik's MMI date of March 5, 2004 and his rating.

5. Claimant continued treating with Dr. Kalevik although he maintained that Claimant was at MMI.

6. On November 7, 2006, the Employer placed the Claimant on leave because it could not accommodate her work restrictions. The Employer subsequently terminated Claimant's employment.

7. Thereafter, Claimant continued to treat with Dr. Kalevik. On April 6, 2007, Dr. Kalevik referred the Claimant to Dr. Anderson-Oeser for EMG studies.

8. Claimant saw Clarence Kluck, M.D. (December 13, 2006), Richard Stieg, M.D. (September 18, 2007), and Rick Schwettmann, M.D. (August 12, 2008), in independent medical examinations (IMEs), all of whom stated that Claimant was not at MMI and needed to be assessed for Complex Regional Pain Syndrome (CRPS).

9. On January 2, 2008, Dr. Kalevik agreed that Claimant's symptoms appeared to be worsening but felt that the worsening was not related to Claimant's job. On January 14, 2008, Dr. Anderson-Oeser agreed that Claimant's symptoms were worsening but did not relate the worsening to Claimant's work. In her re-opening decision of March 10, 2008, ALJ Rumler found that Dr. Anderson-Oeser "failed to reconcile the fact that claimant worked for the employer for 2 years and 8 months after being placed at MMI during which she complained of pain and a worsening of condition," thus, implicitly rejecting Dr. Anderson-Oeser's opinion of lack of causal relatedness. Ultimately, ALJ Rumler made the legal determination that Claimant was **no longer** at MMI AS OF March 10, 2008 and ordered Respondents to pay ongoing medical benefits and temporary total disability (TTD) benefits from November 7, 2006, ongoing. The effect of Dr. Anderson-Oeser's opinion, as a result of her August 2008 examination of the Claimant, that Claimant had reached MMI in 2004 would be to overrule ALJ Rumler's legal determination that the Claimant was **no longer** at MMI as of March 10, 2008.

10. On November 20, 2007, Claimant proceeded to hearing on the following issues: whether the claim should be reopened due to a worsening of condition; whether

Dr. Schwettmann is an ATP; and, whether the Respondents should pay the Claimant temporary disability benefits.

11. In a decision, dated March 10, 2008, ALJ Morgan Rumler found the worsening to be work-related and issued the following order:

- Claimant's petition to reopen is granted.

- Rick Schwettman, M.D., is an authorized treating physician.

- **Claimant is not at MMI** (emphasis supplied)**.** Insurer shall pay for ongoing medical benefits to cure and relieve the effects of Claimant's work-related injury, and temporary total disability benefits from November 7, 2006, ongoing, subject to appropriate offsets and until terminated by law.

12. Respondents filed **no** timely appeal of ALJ Rumler's decision, and it became final by operation of law. Respondents have been providing Claimant benefits since the ALJ Rumler's decision issued on March 10, 2008.

13. Respondents now seek to terminate the benefits that ALJ Rumler ordered, based on opinions of Dr. Anderson-Oeser that ALJ Rumler found unpersuasive. On August 27, 2009, Respondents filed a Motion to Add Termination of Benefits as an Issue for the September 15, 2009 hearing, premised on the opinions of Dr. Anderson-Oeser that Claimant had reached MMI in 2004, as expressed in her April 28, 2009 deposition. In her deposition, Dr. Anderson-Oeser stated, as a result of her August 2008 examination of the Claimant: "…There was nothing new, so I did not see anything new to be treating that we hadn't already treated in the past. A thorough workup had been done, in my opinion, so I felt, yes we were definitely at MMI. (Depo. Tr., p. 14)." When asked when the Claimant was at MMI, Dr. Anderson-Oeser stated: "In 2004."

14. Respondents' exhibit packet for the September 15 hearing contains mostly reports and records upon which ALJ Rumler based her decision. The exceptions are as follows: An order showing that Respondents were ordered on June 20, 2008, to pay for Claimant's travel from Kosovo for an appointment with Dr. Anderson-Oeser; a report of Dr. Schwettmann that was issued on August 13, 2008; excerpts from a deposition with Dr. Anderson-Oeser, as opposed to the entire deposition transcript; and, Dr. Anderson-Oeser's written answers to counsel for Respondents' questions. This comprises the evidence provided by Respondents for the September 15 hearing.

15. Claimant provided the complete deposition transcript of Dr. Anderson-Oeser, which the ALJ has read and considered. Claimant also provided the decision of ALJ Rumler that was mailed on March 11, 2008, and the decision of ALJ Krumreich, which denied summary judgment in this matter on July 29, 2009. In addition, Claimant provided medical records from Dr. Habib in Kosovo where Claimant now resides and receives treatment.

16. Respondents deposed Dr. Anderson-Oeser on April 28, 2009. Dr. Anderson-Oeser testified that Claimant was at MMI in 2004 as follows:

Q. And MMI as of the date of your exam?

A. Actually, I think I thought she was at MMI even before that.

Q. Do you have –

A. I've never really changed my opinion about her MMI status because even with the addition of the electrical unit and Lyrica, I've not seen any dramatic changes in her.

(Depo. Tr., p. 14, line. 25 to p. 15, line 7)

Q. When you say she's at maximum medical improvement, when in your opinion was she at maximum medical improvement?

A. In 2004.

(Depo. Tr. p. 15, lines 20-23)

Q. After everything we've discussed, can you state that your opinion that she reached maximum medical improvement in 2004 is anything more than a disagreement with Dr. Schwettmann and how the ALJ ruled at hearing?

A. Well, it's my opinion and, yes, it is disagreeing with what they said.

(Depo. Tr. p. 45, lines 1-9)

Q. He said based on additional reports. The fact of the matter is that you have simply never changed your opinion that she reached maximum medical improvement in 2004, correct?

A. Right, but that only solidified my opinion.

Q. So you've never changed your opinion?

A. Correct. Any more?

(Depo. Tr. p. 51, lines 11-18)

17. Dr. Anderson-Oeser first saw the Claimant on January 28, 2005. Although she maintained her opinion that Claimant was at MMI in 2004, Respondents' counsel questioned her about what Claimant's impairment rating would have been in 2008 when she saw her for an evaluation.

> Q. Do you have an opinion as to what her impairment would have been as of the time you saw her in August of 2008?
>
> A. Actually, I would have had to calculate it, which I did not do at that time.
>
> Q. So as we sit here you don't have enough information to give us a quantitative difference with what Dr. Kalevik rated her?
>
> A. Correct. I would need to see her again.

(Depo. Tr. p. 16, lines 16-25)

18. Claimant moved to Kosovo after ALJ Rumler reopened her claim. Respondents filed a Motion to Compel Claimant's attendance at a medical examination with ATP Dr. Anderson-Oeser. The Office of dministrative Courts (OAC) entered an order compelling the "evaluation by Dr. Anderson-Oeser, treating physician."

19. Respondents paid for Claimant to return to the United States and she attended medical examinations with Dr. Anderson-Oeser and Rick Schwettmann, M.D., another ATP. Dr. Schwettmann examined the Claimant on August 12, 2008. He made medical recommendations. Dr. Anderson-Oeser examined the Claimant on August 13, 2008. In a February 9, 2009 letter, Dr. Anderson-Oeser agreed with some of the treatment suggested by Dr. Schwettmann's but she also issued an opinion that the Claimant did **not** have CRPS and re-stated that the Claimant was at MMI. She also indicated that the Claimant had permanent impairment.

20. In the deposition of Dr. Anderson-Oeser on April 28, 2009, Respondents and sought clarification of her position on MMI. Dr. Anderson-Oeser testified that her opinion that the Claimant was at MMI was based, in part, on medical records, examination, testing and information generated **after** the claim was reopened. The record reflects that the Claimant also treated with Dr. Schwettman after her claim was reopened. Dr. Schwettmann sent the Claimant for an MRI (magnetic resonance imaging). Dr. Anderson-Oeser referenced Dr. Schwettmann's records and the studies he performed. Dr. Anderson-Oeser stated that this study assisted her in forming her February 9, 2009 conclusions. Thus, her opinion was based upon Dr. Schwettmann's medical records and

opinions and her own August 13, 2008 examination of the Claimant. In her deposition, Dr. Anderson-Oeser testified that her February 9, 2009 conclusions regarding MMI are based on new and different evidence than what was considered at the first hearing.

> Q. After everything we've discussed, can you state that your opinion that she reached maximum medical improvement in 2004 is anything more than a disagreement with Dr. Schwettmann and how the ALJ ruled at hearing?
>
> A. Well, it is my opinion an, yes, it is disagreeing with what they said.

Dr. Anderson-Oeser was further examined on the issue of what forms the basis of her February 9, 2009 opinions. She stated:

> Q. That disagreement is based upon additional evaluations, testing and further examination?
>
> A. Correct.
>
> * * *
>
> Q. I'm thinking. You considered everything that's been since MMI?
>
> A. Yes.
>
> Q. And since the judge reopened the case?
>
> A. Yes, I've taken that into consideration.

21. The ALJ finds that Dr. Anderson-Oeser's opinions are based on documents, information and medical examinations that occurred after the March 10, 2008 Specific Findings of Fact, Conclusions of Law and Order of ALJ Rumler were rendered, even though Dr. Anderson-Oeser believes that the Claimant has been at MMI since the original permanent impairment rating was given by Dr. Kalevik in 2004. This is an opinion purportedly based upon new testing and examinations following the reopening by ALJ Rumler. This opinion would nullify the law of the case that Claimant was **no longer** at MMI AS OF March 10, 2008, and it implicitly reverse ALJ Rumler's legal determination of **no longer** at MMI, based on her finding of a worsening of condition. Logically, an MMI date after a worsening of condition and a reopening would have to follow, in time, the worsening of condition and without the benefit of time travel could not legally operate retroactively.

22. Dr. Anderson-Oeser indicated at her deposition that she has no reason not to reaffirm the original permanent impairment rating of 10% by Dr. Kalevik and his MMI date of March 5, 2004. This testimony reaffirms that Dr. Anderson-Oeser did not accept

ALJ Rumler's determination as a beginning premise but, moreover, sought to overrule this legal determination with her medical opinion.

23. The medical record reflects that the Claimant has had the thermogram, QSART testing, bone-scan, MRI and EMG, which were all negative. It is Dr. Anderson-Oeser's opinion that no additional testing is necessary or reasonable and that CRPS can be ruled out as a diagnosis. One of the reasons that the Claimant's claim was re-opened by ALJ Rumler was to obtain additional testing and evaluation of a claimed CRPS condition. It is Dr. Anderson-Oeser's opinion that CRPS is not a valid diagnosis.

24. Dr. Anderson-Oeser is of the opinion that any future treatment would be for post-MMI medical maintenance benefits, if it, indeed, were related to the original admitted injury. Essentially, Dr. Anderson-Oeser believes that Claimant's present complaints are not related to the original work related injury, despite the law of the case.

25. Although there is no genuine issue of material fact over the content of Dr. Anderson-Oeser's opinions, the legal effect of those opinions are disputed by Claimant and in doubt for the Respondents. Respondents believe that the legal effect of Dr Anderson-Oeser's opinions entitles them to file a Final Admission of Liability, based on those opinions. The Claimant disputes the legal effect of Dr. Anderson-Oeser's opinions, implicitly because acceptance thereof would amount to a "doctor nullification" of the law of the case established by ALJ Rumler, *i.e.,* that the Claimant was **no longer** at MMI. The parties' contend that their respective rights and obligations under § 8-42-107, C.R.S. (2009), need to be determined. Because Respondents have not filed an FAL, the consequences of a proposed FAL are uncertain and/or contingent at this point. Nevertheless, by posturing the matter for a declaratory judgment, the Respondents make a good faith effort to secure guidance in advance, whether or not guidance will be forthcoming.

26. Claimant has failed to prove, by a preponderance of the evidence that Respondents set the matter for hearing on the issue of a "declaratory judgment," when it was not ripe for adjudication at the time of filing the request. As found, Respondents were making a good faith effort to secure guidance from the court before considering the filing of a final admission, based on Dr. Anderson-Oeser's post-reopening opinion of MMI. Therefore, regardless of whether the ALJ would invoke the doctrine of abstention and decline to grant a declaratory judgment, Respondents acted in good faith in posturing the matter for a "declaratory judgment," and the issue was ripe as of September 15, 2009.

DISCUSSION

Although Claimant does not use the phrase "lack of jurisdiction," Claimant implicitly argues that the ALJ lacks jurisdiction to enter a "declaratory judgment" under Rule 57, C.R.C.P., because the Rule states: (a) district or superior courts within their respective jurisdictions shall have the power to declare rights, status and other legal relations whether or not relief is or could be claimed…." Office of Administrative Courts Proce-

dural Rules for Workers' Compensation Hearings (OACRP), Rule 2.B states: "The Colorado Rules of Civil Procedure apply to Workers' Compensation hearings unless they are **inconsistent** (emphasis supplied) with these rules and the provisions of the Workers' Compensation Act (the 'Act')." There is nothing inconsistent in the OACRP or the "Act" with Rule 57 declaratory judgment proceedings. In the face of silence of the Workers' Compensation Act and the OACRP, there is a default to the Colorado Administrative Procedure Act (APA). § 24-4-105 (4), C.R.S. (2009), provides, in pertinent part, that an ALJ may "…take any other action authorized by agency rule consistent with this article or in accordance, to the extent practicable, with the procedure in the district courts (C.R.C.P.)." If the Claimant's argument is accepted, the only logical outcome would be that the Colorado Rules of Civil Procedure could not apply in administrative proceedings because these Rules are reserved for "district or superior courts," as mentioned in Rule 57 (a). Indeed, if an agency so chose, it could make the Colorado Rules of Civil Procedure applicable to agency proceedings, lock, stock and barrel.

§ 8-43-201, C.R.S. (2009) gives the OAC ALJs jurisdiction and authority to hear and decide all matters arising under the Workers' Compensation Act. Claimant has offered no argument as to why "declaratory judgment" procedures are **not** available in the workers' compensation arena, other than making the bald statement that because Rule 57 (a) mentions the district and superior courts, then, "only" the district or superior courts can enter declaratory judgments. This argument of construction embodies a logical fallacy of exclusion when an inference of exclusion is not warranted. The flyer that states that there are elephants and tigers at the zoo does not exclude zebras and giraffes at the zoo. By the same token, a statement in the Rule that district and superior courts may enter "declaratory judgments" does not exclude administrative agencies from doing so. There is nothing in Rule 57 that implicates the inherent powers of courts of general jurisdiction and vitiates a statutory or rule incorporation of the C.R.C.P.

Nonetheless, it would be ill advised for an ALJ of the OAC to enter a declaratory judgment on a matter that Respondents may be legally entitled to do in the first place, regardless of how well, or how ill-advised doing so might be. It is not the proper role of the Office of Administrative Courts (OAC) to place an imprimatur on proposed claims management actions of an insurance carrier, *i.e.,* the filing of a final admission on the basis of an authorized treating physician's opinion. This type of premature intervention, on the Respondent's supplication that it fears a bad faith lawsuit, would be inimical to the self-executing workers' compensation system designed by the General Assembly, with litigation by exception when an actual dispute arises. Only the insurance carrier would know at this point whether it will act in good faith or bad faith, if it filed a final admission, the effect of which would nullify the law of the case previously established by ALJ Rumler in her March 10, 2008 decision. Insurance companies are adults and they are usually prepared to act, unlike those who run from the bulls through the streets of Pamplona, without an official blessing; and, they are prepared to take responsibility for their actions. The OAC is primarily in the business of resolving disputes, the facts of which arose in the past. In the present case, the Respondents have choices that should be made according to their best judgment, not according to the ALJ's speculative guidance.

In their reply brief, Respondents argue that ALJ Rumler's decision is not a "final judgment," and, therefore, the doctrine of issue preclusion is inapplicable. In reopening the case, however, ALJ Rumler established the "law of the case," *i.e.,* that Claimant was **no longer** at MMI, was entitled to TTD benefits, and that the degree of permanent impairment after reopening remained to be determined at a future time, not retrospectively by a former physician who reiterated her previous opinion. Insofar as ALJ Rumler ordered renewed TTD benefits, this portion of her reopening order was a "final judgment." After the reopening, a subsequent ALJ should not nullify the reopening ALJ's established law of the case. A reopening creates a new and superseding "ballgame." *See Anderson v. Longmont Toyota, Inc.*, 102 P.3d 323 (Colo. 2004). The original degree of permanent impairment is inoperative for post-reopened purposes. The previous MMI date is also inoperative. As found, Dr. Anderson-Oeser re-examined the Claimant after ALJ Rumler reopened the case. Claimant's answer brief conveys the impression that Dr. Anderson-Oeser had not re-examined the Claimant after the re-opening. Such an oversight in the answer brief is harmless to a resolution of the issue at hand. Dr. Anderson-Oeser's latest opinion, which re-affirms her 2004 opinion, implicates her credibility and the weight to be accorded her opinions after her subsequent examination. The reopening statute [§ 8-43-303, C.R.S. (2009)] authorizes the reopening of the award and, by implication, all issues thereafter, including TTD and the degree of permanent impairment, are on the table again. Implicit in the reopening is a determination that the Claimant is no longer at MMI. To argue, as argued in the reply brief, that MMI can then be retroactive to a time before the reopening creates a logical conundrum that cannot stand up under close scrutiny. *See Burke v. Industrial Claim Appeals Office,* 905 P.2d 1 (Colo. App. 1994); *Clarke v. Avalanche Industries, Inc.,* W.C. No. 4-471-863 [Industrial Claim Appeals Office (ICAO), March 28, 2006].

The doctrine of the "law of the case" is a discretionary doctrine which directs that prior relevant rulings made in the same case generally be followed. *Verzuh v. Rouse,* 660 P.2d 1301 (Colo. App. 1982). The doctrine, however applies only to decisions of law. *Mining Equipment, Inc. v. Leadville Corp.,* 865 P.2d 81 (Colo. App. 1993). As found, ALJ Rumler's determination that Claimant was **"no longer at MMI,"** was a legal determination that established the law of the case.

Based on the facts found, the Claimant's argument concerning issue preclusion is without merit because the issues are not postured **identically**, after the reopening as they were at the time the March 10, 2004 Final Admission of Liability was filed. There are new facts, post-reopening, which defeat an application of the doctrine of "issue preclusion." The ingredients of the doctrine of "issue preclusion" are: (1) the issue sought to be precluded is **identical** to an issue actually determined in the prior proceeding; (2) the party against whom estoppel is asserted has been a party to or is in privity with a party to a prior proceeding; (3) there is a final judgment on the merits in the prior proceeding; and (4) the party against whom the doctrine is asserted had a full and fair opportunity to litigate the issue in the prior proceeding. All of these elements are necessary to apply the doctrine of "issue preclusion." *SeeSunny Acres Villa, Inc. v. Cooper,* 25 P.3d 44 (2001); *Feeley v. Industrial Claim Appeals Office*, 195 P.3d 1154 (2008). If the doctrine

of issue preclusion or "law of the case" should apply as Claimant argues it should, then, a workers' compensation case could never be reopened because litigating the issue of permanent impairment and MMI would be precluded if previously determined before a reopening. This cannot be because a reopening creates a new ballgame where subsequent MMI and permanent impairment are yet to be determined. It would be self-contradictory to determine that Respondents request for a declaratory judgment is not ripe because a dispute concerning the matters underlying the request for a declaration of rights and obligations has not yet arisen. Such an argument would amount to thinly disguised sophistry. Asking for a hearing on permanent impairment before a determination of MMI would not be ripe. Asking for a determination of permanency while a Division Independent Medical Examination (DIME) is pending would not be ripe.

Lastly, ALJ Ted Krumreich denied Respondents "Motion for Summary Judgment" on the identical issue postured for a "declaratory judgment" herein, *i.e.,* granting Respondents leave to file a Final Admission of Liability (FAL), based on Dr. Anderson-Oeser's re-affirmation of her previous rating and MMI determination after re-examining the Claimant subsequent to ALJ Rumler's reopening of Claimant's claim. ALJ Krumreich withheld adjudication on a contingent future matter, *i.e.,* the potential consequences of Respondents filing a FAL based on Dr. Anderson-Oeser's subsequent opinions.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

a. A reopening under the provisions of § 8-43-303, C.R.S. (2009), creates a new situation whereby there could be a new MMI date and a new degree of permanent impairment. The pre-reopened case is superseded by the reopening. *See Anderson v. Longmont Toyota, Inc., supra.* As found, Dr. Anderson-Oeser re-examined the Claimant after the re-opening and rendered an opinion that her original opinion on MMI and degree of permanent impairment was the same as her former opinion. The reopening statute authorizes the reopening of the award and, by implication, all issues thereafter including MMI, TTD and degree of permanent impairment. *See Burke v. Industrial Claim Appeals Office,* 905 P.2d 1 (Colo. App. 1994); *Clarke v. Avalanche Industries, Inc.,* W.C. No. 4-471-863 [Industrial Claim Appeals Office (ICAO), March 28, 2006]. As found, implicit in the reopening is the determination that the Claimant is no longer at MMI. To postulate that MMI can pre-date the reopening, although based on a new examination by a former ATP who reiterates the "same old, same old" opinion of MMI in 2004, would create a logical conundrum that makes no sense.

b. § 8-43-201, C.R.S. (2009) gives AJs from the Office of Administrative Courts jurisdiction and authority to hear and decide all matters arising under the Workers' Compensation Act. An ALJ of the Office of Administrative Courts is not precluded from entering a declaratory judgment under the provisions of Rule 57, C.R.C.P, by virtue

of § 8-43-201, C.R.S. (2009), OACRP, Rule 2, and § 24-4-105 (4), C.R.S. (2009). Nevertheless, the LJ determines that it would be ill advised to grant Respondents a declaratory judgment under the specific circumstances of this case.

c. Ordinarily, an insurance carrier cannot do an end-run around the law of the case, to wit, an ALJ's legal determination that a claimant is **no longer at MMI** and a resulting reopening. Where a former ATP can reaffirm a previous opinion that would, for all practical purposes, nullify and render meaningless the ALJ decision that the claimant is **no longer** at MMI, would render the ALJ decision-making process an exercise in futility. *See Lockhart v. Tetra Technologies,* W.C. 4-725-760, (Industrial Claim Appeals Office, May 21, 2009). The doctrine of the "law of the case" is a discretionary doctrine that directs that prior relevant rulings made in the same case generally be followed. *Verzuh v. Rouse,* 660 P.2d 1301 (Colo. App. 1982). The doctrine, however applies only to decisions of law. *Mining Equipment, Inc. v. Leadville Corp.,* 865 P.2d 81 (Colo. App. 1993). As found, ALJ Rumler's determination that Claimant was **"no longer at MMI,"** was a legal determination that established the law of the case.

d. As found, it would be imprudent to enter a declaratory judgment under the particular circumstances of this case. Adjudication should be withheld for uncertain or future contingent matters that suppose a speculative event that may never occur. *Olivas-Soto v. Industrial Claim Appeals Office*, 143 P.3d 1178 (Colo. App. 2006). To declare that Respondents may file a Final Admission of Liability herein, based on Dr. Anderson-Oeser's latest opinion (which is ultimately the same as her previous 2004 opinion) would unduly interfere with the internal management decisions of the insurance carrier, encourage litigation of hypothetical issues and set the Office of Administrative Courts up as a consultant for insurance company approaches to the handling of workers' compensation claims. *See Heron v. City and County of Denver*, 159 Colo. 314, 411 P.2d 314 (1966) [courts should not be converted into "legal aid bureaus" to answer questions that have not yet arisen and which may never arise]. Such a declaratory judgment would undermine the self-executing nature of the Colorado workers' compensation system.

e. § 8-43-211 (2) (d), C.R.S. (2009), provides that if a persons requests a hearing on issues that are not ripe for adjudication at the time such request is made, such person shall be assessed reasonable attorney fees and costs of the opposing party in preparing for such hearing. Based on the above findings of fact, the ALJ concludes that Respondents postured a reasonably debatable controversy, and they sought a declaratory judgment in good faith. For these reasons, the issue of declaratory judgment was ripe at the time the hearing thereon was requested and it was ripe at the time of the hearing. Therefore, Claimant is **not** entitled to attorney fees or costs.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents' Motion for a Declaratory Judgment is hereby denied and dismissed.

B. Claimant's request for attorney fees and costs is hereby denied and dismissed.

C. Any and all issues not determined herein are reserved for future decision.

DATED this 5 day of October 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-789-662

ISSUES

The issues endorsed for hearing include: compensability; average weekly wage; medical benefits; change of physician; and insurance coverage. At the outset of the hearing, the parties entered into the following stipulations before this Administrative Law Judge.

STIPULATIONS

1. The parties stipulate and agree that Liberty Mutual is the responsible carrier in this matter and agrees to file a General Admission of Liability for the injuries sustained by claimant on March 12, 2009.

2. The parties stipulate and agree that Pinnacol Assurance is not the responsible carrier in this matter and therefore stipulate and agree that Pinnacol Assurance shall be dismissed, with prejudice, from this workers' compensation matter.

3. The parties stipulate and agree that the proper captioning in this matter shall be _, claimant, v. _ as respondent-employers and Liberty Mutual as respondent-insurer.

4. The parties stipulate and agree that claimant's average weekly wage is $441.08.

5. The parties stipulate and agree that the General Admission of Liability shall admit for temporary total disability benefits commencing March 26, 2009 and continuing until terminated by statute, rule of procedure, or order.

6. The parties stipulate and agree that Dr. Frank Polonco is an authorized treating provider in this matter.

7. The parties stipulate and agree that as of September 30, 2009 claimant's primary authorized treating provider shall be changed to Dr. George Schwender or, if Dr. Schwender declines to treat the claimant, the primary authorized treating provider shall be Dr. Kenneth Finn.

ORDER

Based upon the preceding stipulations, the ALJ enters the following Order:

1. The parties' stipulations are accepted by this court.

2. Pinnacol Assurance is hereby dismissed, with prejudice, from this matter.

3. All further pleadings shall reflect the amended captioning of this claim.

4. All matters not specifically addressed by the stipulations of the parties are reserved for future determination.

All matters not determined herein are reserved for future determination.

DATED: October 5, 2009

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-765-974

ISSUES

The combined workers' compensation claims, which were consolidated for hearing, raised the issues of compensability, temporary total disability benefits, average weekly wage (stipulated at hearing) and penalties for failure to admit or deny a lost time claim. Respondents raised the defenses of compensability for lost time, the statute of limitations, *laches*, offsets, and Claimant's responsibility for termination of employment.

FINDINGS OF FACT

1. Claimant worked as a service technician for Employer. He used an Employer van to travel to various locations to install equipment for both commercial and residential accounts.

2. Claimant filed a claim for workers' compensation benefits in 2008, claiming a low back injury on August 18, 2002. Respondents had treated the low back injury as a "medical only" claim for six years. Claimant had been referred for treatment and subsequently released to return to work as a service technician.

3. It was Claimant's position at hearing that there was only one actual low back injury and that occurred on August 18, 2002. Although Respondents and the authorized medical care providers may have referenced other subsequent injury dates, it is Claimant's position that there were no subsequent significant injuries.

4. 4-765-974 (D.O.I. 8/18/02):

a. Claimant sustained a compensable injury on August 18, 2002. He was adjusting a ladder leaning against a pole when he felt a sharp pain in his back. Claimant filed a claim for workers' compensation on July 24, 2008. Insurer filed a Notice of Contest on September 17, 2008.
b. Claimant was treated at Concentra for this injury. He was placed at maximum medical improvement (MMI) on September 9, 2002. Claimant had not missed any time from work when he was placed at MMI.
c. Claimant experienced severe low back pain on October 23, 2002. Dr. Bahhage recorded a history that Claimant had "low back pain for one month" and that Claimant "does not recall injury or fall prior to start of pain." This is approximately the same time that Claimant had an interview with the adjuster and stated that the claim was not related to his incident in August 2002.
d. Respondents admit that the Claimant had a "medical only" incident in August 2002. There was a referral to Concentra as the treating facility and Claimant was treated and released to return to work. Claimant was also treated by a chiropractor in November 2002. Claimant told the chiropractor that his condition was related to the August 18, 2002, compensable injury.
e. Claimant, from October 29, 2002, through November 14, 2002, was not allowed to go into the field as a service technician, but was required to come in and do alternative light work, such as shredding paper. Claimant had admitted difficulties remembering specific conversations with the adjuster, the dates and times he lost from work and the physicians he saw and when he saw them. Claimant testified that even when he was injured or sick, he was required to come into work. He testified that when he could not even sit or stand, he was still required to come in for his work from 8:00 a.m. until 4:00 p.m., even when he had to lay on the floor from the pain. He also testified that his supervisor found things for him to do, such as shredding paper, when he came in for light duty. Claimant was just not allowed to go into "the field" and perform regular duties. He further testified that the lost time reflected in the short-term disability form may have been from when he was sick and not related to any of his industrial injuries. Claimant confirmed the fact that even when he was "injured or sick," he was paid his full salary. Claimant's testimony on missing more than three days or three shifts from is not clear. Claimant's testimony is not persuasive on this issue.
f. Medical records show a release to restricted or full duty on numerous occasions and do not reflect any periods of time when Claimant was incapable of working.

g. Claimant and the adjuster had a conversation about whether his condition in October and November 2002 was related to the August 18, 2002, accident. The reasonable inference from the claims notes was that the adjuster was not informed that there was "any other claim." This is combined with Claimant's own testimony at hearing

that even when he was injured or sick, he was required to come into work, even when he could not sit or stand. Claimant's allegation that he lost more than three shifts or three days from work is unsubstantiated.

5. 4-781-396 (D.O.I. 1/10/06):

a. Claimant got down from a company truck on January 10, 2006, and felt pain his low back, mid-back, neck, and hip.

b. Claimant was placed at MMI on April 5, 2006. A Final Admission was filed on April 12. 2006.

c. Claimant does not request any benefits in this claim at this time. 6. 4-740-418 (D.O.I. 10/26/07):

a. On October 26, 2007, Claimant was walking towards a customer's home and felt pain in his lower back. Jeremiah J. Cogan, M.D., examined Claimant on October 29, 2007. Dr. Cogan stated that Claimant was suffering from "lumbar pain without radiculopathy/strain." Dr. Cogan prescribed physical therapy and restricted Claimant from lifting, pushing, or pulling more than fifteen pounds or bending more than five times per hour. Claimant was instructed to follow up in two or three weeks. MMI was anticipated in four to six weeks. There is no record that Claimant followed up. Claimant suffered an aggravation to his previous condition on October 26, 2007.

b. Claimant's employment was terminated by Employer in March 2008. Maley had been Claimant's supervisor for a period of three months prior to the termination. He was aware of no restrictions on Claimant and testified that Claimant was not restricted from any portion of his regular duties to his knowledge. Claimant had a ladder on his truck and was servicing both residences and apartments.

c. Claimant testified that he was not responsible for termination of his employment and that his supervisors were aware of his restrictions. Maley testified that Claimant was terminated for violating Employer's policy and deviating from his assigned routes.

d. Maley testified that he was briefed by Claimant's former supervisor and was never advised of any restrictions on Claimant's employment during his last three months of employment under Maley's supervision. Maley credibly testified that Claimant was assigned the normal duties of a service technician, without any restrictions. Maley had worked as a service technician and was aware of the requirements for the service technician position that Claimant held.

CONCLUSIONS OF LAW

1. An injured worker bears the burden to prove by a preponderance of the evidence that he sustained an injury arising out of the course and scope of employment

for which indemnity benefits are payable. *City of Boulder v. Streeb*, 706 P.2d 786, 789 (Colo. 1985); Colo. Rev. Stat. §8-41-301 (2009). A preponderance of the evidence standard is met when the "existence of a fact is more probable than its non-existence." *Industrial Comm'n v. Jones*, 688 P.2d 1116, 1119 (Colo. 1984). Respondents have admitted compensability; it is indemnity benefits that are contested.

2. Respondents are required to send an Employer's First Report of Injury to the Division of Workers' Compensation when notified of a compensable lost time injury. Section 8-43-101(1), C.R.S. Injuries that result in fewer than three lost days or that result in no permanent physical impairment must be reported by the Employer's First Report of Injury only to the insurer. Section 8-43-101(2), C.R.S. In this case, a First Report of Injury was completed but not filed with the Division.

3. A Claimant also has the burden of proof to prove the employer had sufficient knowledge of a compensable lost time injury to trigger reporting duties. *See*, *City and County of Denver v. ICAO,* 58 P.3d 1162 (Colo.App. 2002). It is a question of fact whether the employer was placed on notice of lost time sufficient to trigger the reporting requirement. *Wallace v. Stone Gate Homes*, W.C. No. 650-504 (ICAO, April 18, 2006) and *Doughty v. PVH*, W.C. No. 4-488-749 (ICAO, January 12, 2003).

4. Claimant has not established by a preponderance of the conflicting evidence that Respondents were presented with notice of a lost time injury. If Claimant was required to come into work and paid full salary, even when he was injured or "sick" as his testimony suggests, then he did not lose three days from work in October and November 2002. Claimant has not met his burden of proof.

5. Claimant has not established that he missed three days from work. There is no requirement for Respondents to file the First Report of Accident with the Division of Workers' Compensation.

6. Claimant has proven, and Respondents do not contest, that he had an accident at work on August 18, 2002. However, Claimant has failed to meet his burden of proof that he communicated that he was losing time from work to his employer and has failed to establish that he lost any time from work.

7. Respondents paid for necessary and reasonable medical care through Concentra for treatment of Claimant's back complaints. The medical records produced at hearing show a release to restricted or full duty on numerous occasions and do not reflect any periods of time when Claimant was incapable of working.

8. Claimant has the burden of proof to establish the right to a penalty. *Long v. DBF, LLC.,* W.C. No. 4-264-006 (ICAO, June 5, 1997). Assessment of a penalty for alleged untimely admission or denial is permitted only when a claimant is successful in the claim for indemnity benefits. Success in the context of the penalty is an award of indemnity benefits. *Racon Const. Co. v. ICAO,* 775 P.2d 61 (Colo.App. 1991). An award or admission of medical benefits is not a sufficient penalty trigger.

9. There is also no persuasive evidence that Claimant was disabled at the time his employment was terminated in March 2008. Claimant admitted that he was working full time. Although he claims that he was under restrictions, his supervisor credibly testified that he was working full duty without any known restrictions and would have continued to work but for his termination. Maley's testimony was credible and persuasive. Claimant has failed to meet his burden of proof that he was disabled at the time he was terminated.

10. In W.C. 4-765-974, Claimant has failed to establish by a preponderance of the evidence that he sustained any temporary total or temporary partial disability as a result of this compensable injury. With regard to the penalty alleged in W.C. 4-765-974, the compensable claim did not result in any lost time and it has not been shown that there was any impairment. Respondents were not required to report the injury to the Division. Section 8-43-101(1), C.R.S.

11. With regard to W.C. 4-740-418 (D.O.I 10/26/07), Claimant has established that he sustained an aggravation of his pre-existing condition. Insurer is liable for medical benefits. Section 8-42-101(1), C.R.S.

12. Claimant was not a "temporarily disabled worker" when his employment was terminated in March 2008. Therefore, Section 8-42-103(g), C.R.S., does not apply. The issue of responsibility for termination is not reached. Claimant's compensable injury did not contribute to some degree to the wage loss after termination. See *PDM Molding Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Claimant is not entitled to temporary disability benefits commencing when he was terminated in March 2008.

ORDER

It is therefore ordered that:

1. Claimant's request for temporary disability benefits is denied.

2. Claimant's request for penalties is denied.

3. Insurer is liable for authorized medical care from Dr. Cogan for the October 26, 2007, aggravation.

4. All matters not determined herein are reserved for future determination.

DATED: *October 5, 2009*

Bruce C. Friend, Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-722-053

ISSUES

The issue for determination in W.C. 4-672-379 is permanent partial disability benefits (schedule or whole person).

The issues for determination in W.C. 4-722-053 are compensability, medical benefits, average weekly wage, and temporary total disability benefits

FINDINGS OF FACT

1. Claimant sustained a compensable injury as a result of a fall on April 21, 2005. He suffered multiple contusions and abrasions. He had left shoulder and knee pain that was treated conservatively.
2. Robert R. Maisel, M.D., an authorized treating physician, placed Claimant at maximum medical improvement (MMI) on December 12, 2005. He noted that Claimant had residual pain in his foot, knee, and shoulder. Dr. Maisel restrictions included limitations on lifting overhead and no shoulder activities that include the use of his left arm. Using the revised third edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment", he rated Claimant impairment at twelve percent of the knee and six percent of the upper extremity. Dr. Maisel converted the six percent upper extremity rating to four percent of the whole person.
3. Gareth Shemesh, M.D., performed the Division independent medical examination (DIME) on June 12, 2006. He noted that Claimant had suffered a twisting injury to his left shoulder. Dr. Shemesh noted that Claimant reported symptoms primarily involving his left shoulder and right knee. He noted that the left shoulder pain was located primarily along the superior and anterior aspect. Claimant reported continued stiffness in his left shoulder and difficulty lifting his arm. Some pain radiated into the left posterior girdle musculature and along he left side of his neck. Claimant had full range of motion of the cervical spine. Mild tenderness was noted along the trapezius muscle on the left extending into the inferior aspect of the lateral cervical spine on the left. Dr. Shemesh found a range of motion deficit of the left shoulder. In his assessment he noted persistent left shoulder pain and stiffness. He recommended that Claimant avoid repetitive overhead use of the left upper extremity. He rated Claimant's impairment at nine percent of the left upper extremity, which he converted to five percent of the whole person. He also rated Claimant with an impairment of seven percent of the lower extremity.
4. The situs of Claimant's function impairment is to the knee and to the shoulder. His upper extremity impairment is not limited to the arm at the shoulder. Rather, the impairment is to the shoulder itself, including the superior and anterior aspect of the shoulder, the left posterior girdle musculature, the trapezius, and along the left side of the neck.
5. On April 25, 2007, Claimant stood up after working on a utility box for Employer. He testified that as he got up, his knee gave out, and he fell sustaining an injury. He testified that this occurred on a surface of broken shale, but that he did not slip or trip on

the shale. He testified that his knee had given out from time to time since the April 2005 injury.

6. An MRI of the right knee on July 6, 2005 showed intact ligamentous structures and no evidence of a meniscal tear. An MRI taken five days after the fall on April 30, 2007, showed no evidence of internal derangement. The 2007 MRI showed improvement from the previous MRI.

7. In his report and in his deposition testimony, Dr. Olsen stated that it was not medically probable or possible that Claimant's right knee gave out on April 25, 2007. The opinion of Dr. Olsen is credible and persuasive.

CONCLUSIONS OF LAW

1. Section 8-42-107(1), C.R.S. provides that a claimant is limited to an award of permanent partial disability benefits based on an extremity rating if the claimant's injury is described in the schedule set forth in Section 8-42-107(2), C.R.S. *See Strauch v. PSL Swedish Health Care System*, 917 P.2d 366 (Colo.App. 1996). Conversely, if a claimant has sustained an injury not enumerated on the schedule, the claimant is entitled to benefits based upon a whole person impairment rating under Section 8-42-107(8), C.R.S. *Mountain City Meat v. Oqueda*, 919 P.2d 246 (Colo. 1996). For purposes of Section 8-42-107(1), the term "injury" does not refer to the site of the injury or to the site of any ensuing surgery or treatment. Rather, the term refers to the part of the body that has been functionally impaired or disabled as a result of the injury. *Strauch v. PSL Swedish Health Care System, supra.* There is no requirement that functional impairment for these purposes take any particular form. Pain and discomfort that interferes with a claimant's ability to use a portion of the body may be considered "impairment" for purposes of assigning a whole person impairment rating. Under Section 8-42-107(2)(a), C.R.S., the partial "loss of an arm at the shoulder" is a scheduled disability. Depending upon the facts of a particular claim, damage to the "shoulder" may or may not reflect functional impairment enumerated on the schedule of benefits. *Walker v. Jim Fuoco Motor Co.,* 942 P.2d 1390 (Colo.App. 1997). The disputed issue to be resolved is whether Claimant sustained functional impairment not enumerated on the schedule of benefits. *See Aligaze v. Colorado Cab Co.,* W.C. 4-705-940 (ICAO, April 29, 2009).

2. Claimant has established by a preponderance of the evidence that the part of the body functionally impaired or disabled as a result of the April 2005 compensable injury is the shoulder. The injury is not to the "arm at the shoulder" as is enumerated on the schedule of benefits. Section 8-42-107(2)(a), C.R.S. The injury to Claimant's upper extremity is properly compensated as a whole person impairment pursuant to Sections 8-42-107(8)(c) and (d), C.R.S.

3. In W.C. No. 4-672-379, Insurer shall pay Claimant permanent partial disability benefits based on an impairment of five percent of the whole person and seven percent of the lower extremity. Insurer may credit any previous payments of permanent partial disability benefits. Insurer shall pay interest at the rate of eight percent of any benefits not paid when due. Section 8-43-410, C.R.S.

4. In order to establish that an injury is compensable, a claimant must prove that the injury "arose out of" his employment. Sections 8-41-301(1)(b) & (c), C.R.S. An injury arises out of employment if it is sufficiently related to the conditions and circumstances under which the employee generally performs his job functions such that the activity

may reasonably be characterized as an incident of the employment. *Price v. Industrial Claim Appeals Office,* 919 P.2d 207 (Colo. 1996). The question of whether a claimant met his burden to prove a compensable injury is one of fact. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251 (Colo.App. 1999). However, there is no presumption that a fall at work is compensable. An unexplained fall at the workplace has been determined not to be compensable. *See Rice v. Dayton Hudson Corporation* W. C. No. 4-386-678 (July 29, 1999) (claimant's unexplained fall was not compensable because it could not be associated with the circumstances of the claimant's employment nor any preexisting idiopathic condition) *See also, Finn v. Industrial Commission*, 165 Colo. 106, 437 P.2d 542 (1968). The resolution of this issue is one of fact based on an examination of the totality of the circumstances. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office,* 907 P.2d 715 (Colo.App. 1995). *See Aguilar v. Checks Unlimited,* W.C. 4-761-110 (ICAO, April 30, 2009).

5. Claimant was injured at work on April 25, 2007. Claimant did not slip or trip on the loose shale. Claimant testified that his knee gave out. However, the opinion of Dr. Olsen that it is not medically probable that Claimant's knee gave out is credible and persuasive. Claimant has failed to establish by a preponderance of the evidence that his knee gave out on April 25, 2007, resulting in the fall and injuries.

6. Claimant has failed to establish by a preponderance of the evidence that his injuries on April 25, 2007, where the natural result of his previous compensable injury.

7. Claimant has failed to establish by a preponderance of the evidence that he sustained a compensable injury on April 25, 2007. W.C. 4-722-053 is not compensable.

8. Claimant request for medical benefits and disability benefits following the April 25, 2007, fall is denied.

ORDER

It is therefore ordered that:

1. In W.C. No. 4-672-379, Insurer shall pay Claimant permanent partial disability benefits based on an impairment of five percent of the whole person and seven percent of the lower extremity. Insurer may credit any previous payments of permanent partial disability benefits. Insurer shall pay interest at the rate of eight percent of any benefits not paid when due.

2. W.C. 4-722-053 is denied and dismissed.

3. Claimant's request for medical benefits and disability benefits for the fall in April 2005 is denied.

DATED: *October 5, 2009*

Bruce C. Friend, Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-734-252

ISSUES

The sole issue for determination is Claimant's average weekly wage (AWW).

FINDINGS OF FACT

After consideration of the evidence, including the submissions of the parties and the testimony at hearing, the ALJ enters the following Findings of Fact:

1. Claimant sustained an admitted injury during the course and scope of her employment on September 1, 2007. At the time of her injury, Claimant had been employed by the Employer since 1990.

2. On October 5, 2007, Respondents filed a General Admission of Liability admitting to an AWW of $642.29. This amount was based on an October 4, 2007, letter from Judson Haims, the accounting manager for the Employer, stating Claimant's wages from August 31, 2006, to August 31, 2007, were $33,582.56.

3. Subsequently a second statement from Mr. Haims was received on October 16, 2007, reflecting a full year of wages from August 31, 2006, to August 31, 2007, as $40,725.56.

4. On October 23, 2007 a new General Admission of Liability was filed reflecting an AWW of $778.90 based on Mr. Haims' October 16, 2007, report.

5. Claimant testified at hearing her wages were based both on an hourly salary and on commissions received due to sales of fur items. This salary breakdown is consistent with the information Mr. Haims provided on October 16, 2007, reflecting regular pay, overtime, and commissions.

6. Elizabeth Oge, the adjuster presently assigned to the claim, testified that she, and other adjusters, regularly rely on wage statement information received from the employer in admitting AWW. Kathleen Densen, owner of the Employer, testified she had no reason to believe the calculations provided by Mr. Haims were incorrect as he is responsible for payroll and bookkeeping for the business.

7. Claimant alleged at hearing that the figure provided by Mr. Haims in the October 16, 2007, report is incorrect. However, in support of this argument Claimant failed to provide the wage records for the total period in issue, submitting into evidence her paychecks from December 29, 2006 through April 30, 2008. At hearing, claimant specifically declined to submit any additional wage records in support of her arguments.

8. Absent proof to the contrary, given the testimony of Mr. Densen, the ALJ finds the figures provided by Mr. Haims are presumed correct representations of the wages earned by Claimant between August 31, 2006 and August 31, 2007, the full year prior to Claimant's admitted injury.

9. Claimant argues that her AWW should be calculated based on earnings from January 1, 2007 to August 31, 2007, and that her wages should include amounts received during a period of unemployment from approximately mid April 2008 to early July 2008. Alternatively, Claimant argues that only the period of July 2, 2007, through September 1, 2007, should be utilized in calculation of the AWW.

10. The ALJ find that a full year of wages prior to the injury is a better representation of Claimant's earnings than more limited periods of employment. Also, it is found that unemployment benefits are not included for purposes of calculating the AWW.

11. Claimant also argues that the value of the Employer's payment of supplemental health insurance coverage of $140.00 per month, or $32.30 per week, should be included in the AWW.

12. At hearing, Claimant also raised an argument that the value of a one time trip taken to Montreal should be included as a "fringe benefit" in the calculation of her AWW. Claimant testified that the trip was a yearly event for the Employer, but she had only accompanied the Employer on one occasion. The trip involved viewing merchandise at a fur show. Claimant learned information about the merchandise that assisted her in sales in her position for the Employer. All Claimant's expenses were covered by the Employer for the trip.

13. Respondents' arguments are persuasive and accepted in reaching the determination that the admitted AWW of $778.90 is correctly calculated. This AWW is based on the wage statement submitted by Mr. Haims for a full year of work because it constitutes a fair and correct means of calculating the AWW under the Workers' Compensation Act.

14. This ALJ rejects Claimant's request to include unemployment benefits in the AWW calculation and rejects Claimant's assertion that the trip to Montreal constitutes a fringe benefit that should be included in the calculation of AWW. The trip to Montreal occurred in May 2007, a time when Claimant filed for unemployment benefits. Ms. Densen credibly testified that at the time of the trip to Montreal Claimant was on a "work-attached" layoff from the Employer. Therefore, it is found that at the time the Montreal trip occurred Claimant was not acting as an employee of the Employer. Claimant was not "on the clock" during the trip to Montreal. She was not paid any wages during the trip.

15. This ALJ accepts Claimant's arguments that the Employer's contribution to the supplemental Medicare policy of $32.30 per week should be included in Claimant's AWW.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ draws the following conclusions of law:

1. AWW is the money rate at which services rendered are recompensed under the contract of hire "at the time of the injury." Section 8-40-201(19)(a). Section 8-40-201(19)(b) provides that the term "wages" shall include the reasonable value of board, rent, housing, and lodging received from the employer, the reasonable value of which shall be fixed and determined from the facts in each particular case. Section 8-42-102(2)(d), C.R.S., sets forth the method for calculating the AWW. The overall purpose of the statutory scheme is to calculate "a fair approximation of the claimant's wage loss and diminished earning capacity." *Campbell v. IBM Corp*., 867 P.2d 77 (Colo. App. 1993). Section 8-42-102(3) C.R.S. 2008 provides that the ALJ, in each particular case, may compute the average weekly wage in such a manner and by such method as will, in the opinion of the ALJ, fairly determine the employee's AWW. There is no ipso facto rule requiring the ALJ to deviate from the calculation of wages beyond those identified in Section 8-40-201(19)(a). *Jefferson County Public Schools v. Dragoo*, 765 P.2d 636, 637 (Colo. App. 1988).

2. This ALJ finds that a full year of wages, specifically the period of August 31, 2006, through August 31, 2007, represents a fair means by which to calculate Claimant's average weekly wage. This ALJ rejects Claimant's assertion that Mr. Haims' calculation of Claimant's earnings provided to Respondents on October 16, 2007 was incorrect because insufficient evidence was presented to rebut his calculation. Therefore, $40,725.56 is accepted as an accurate statement of Claimant's wages from August 31, 2006 through August 31, 2007.

3. As presented in testimony, Claimant works for a fur sales business and a portion of her income is based on commissions from sales. This ALJ finds, consistent with the testimony presented regarding the nature of the business, that wages from any sales based position can fluctuate and finds the fairest representation of Claimant's base wages is a full year of employment since a full year of wages inherently would take into account any ebb and flow of the business. Claimant presented no evidence that she received a raise in base salary or commission percentage during 2007, which would render the use of the 2006 portion of the full year's wages unfair in calculating AWW. Therefore, because Claimant has presented no persuasive argument why a seven month period or a two month period is a better reflection of the AWW than the 12 month period upon which the AWW admitted to by Respondents was based, this ALJ rejects Claimant's argument that the period of January 1, 2007, through August 31, 2007, or the period of July 2, 2007, through September 1, 2007, represents a fairer reflection of the Claimant's earnings capacity that would support deviating from calculating the AWW based on a full year of wages prior to the September 1, 2007 injury.

4. With respect to Claimant's argument for inclusion of the unemployment benefits in the calculation of her average weekly wage, the ALJ rejects Claimant's argument. Relying on the case of *Craig v. Western Colorado Recycling*, W.C. No. 3-065-856 (ICAO February 27, 1991), it is concluded that benefits payable for unemployment compensation are not included within the definition of benefits which make up Claimant's AWW. As the court in *Craig* noted,

> Section 8-40-201(19), C.R.S. (1990 Cum. Supp.), defines "wages" for purposes of the Workers' Compensation Act as "the money rate at which the services rendered are recompensed under the contract of hire in force at the time of the injury, either express or implied." Because unemployment compensation benefits are not paid pursuant to a "contract of hire" they are not properly included in the claimant's average weekly "wage" under section 8-42-102, C.R.S. (1990 Cum. Supp.). *Cf. St. Mary's Church & Mission v. Industrial Commission*, 735 P.2d 902 (Colo. App. 1986).

5. While the *Craig case* was decided under a prior statute, the definition of "wages" under the present statute is substantially similar to the definition under *Craig* as "average weekly wage" is the money rate at which services rendered are recompensed under the contract of hire "at the time of the injury." Section 8-40-201(19)(a). The ALJ concurs with the rationale of *Craig* and does not find unemployment insurance benefits to be a "fringe benefit" or other calculable benefit includable in the calculation of AWW.

6. The ALJ also rejects Claimant's argument that the value of hotel and food paid during a trip to Montreal constitute an includable fringe benefit. First, the ALJ recognizes that the trip to Montreal occurred in May 2007, a time during which Claimant had filed for unemployment benefits. Ms. Densen testified that at the time of the trip to Montreal Claimant was on a "work-attached" layoff from the Employer. Therefore, it is found that the time the Montreal trip occurred Claimant was not acting as an employee of the Employer. Claimant was not "on the clock" during the trip to Montreal. She was not paid any wages during the trip. Furthermore, at the time of the injury on September 1, 2007, Claimant was not receiving any lodging or meal benefits from the Employer. Testimony was presented the trip to Montreal was an isolated occurrence, Claimant having gone "once" according to Ms. Densen, and "twice" according to Claimant over her 17 years of employment. Claimant's request to include the value of meals or lodging resulting from the Montreal trip in the calculation of Claimant's average weekly wage is rejected.

7. Lastly, Claimant argues the value of the supplemental insurance policy through Medicare paid for by the employer should be included in her average weekly wage. A claimant's average weekly wage is determined by reference to Section 8-40-201(19)(b), which provides that the term "wages" shall include the amount of the employee's cost of continuing the employer's group health insurance plan and, upon termination of the continuation, the employee's cost of conversion to a similar or lesser insurance plan. In this regard, it is concluded that the $32.30 per week paid by the Employer for supplemental health insurance at the time of the Claimant's injury shall be included in Claimant's average weekly wage.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, the ALJ enters the following Order:

1. Claimant's AWW is $811.20 and it is ordered that all admitted periods to temporary and permanent disability benefits be adjusted to reflect this AWW.

2. All other issues not decided by this order are reserved for future determination.

3. The Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

4. All matters not determined herein are reserved for future determination.

DATED: October 5, 2009

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-764-458 & WC 4-780-145

ISSUES

¬ Did the claimant prove by a preponderance of the evidence that on June 30, 2008, she sustained a right wrist injury arising out of and in the course of her employment?

¬ Did the claimant prove by a preponderance of the evidence she is entitled to reasonable and necessary medical benefits as a result of the alleged injury of June 30, 2008?

¬ Did the claimant prove by a preponderance of the evidence that she sustained an occupational disease of the right upper extremity and neck proximately caused, aggravated or accelerated by the hazards of her employment?

¬ Did the claimant prove by a preponderance of the evidence that she is entitled to medical and temporary total disability benefits as a result of the alleged occupational disease?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

1. WC 4-764-458 concerns a right wrist injury that the claimant allegedly sustained on June 30, 2008. WC 4-780-145 concerns a right upper extremity and neck injury allegedly sustained on December 13, 2008. Because of common questions of fact and some overlapping evidence these claims were consolidated for purposes of hearing. The ALJ has determined that it is best to issue a single order resolving the issues in both cases.

2. In 2007, the claimant sustained a work related trigger finger. Several physicians, including Dr. Henry Roth, M.D, treated this condition. This injury is not the subject of either of the claims currently before the court.
3. The claimant was employed as a bus driver. At approximately 7:30 a.m. on June 30, 2008, the claimant was driving a shuttle bus on the 16th Street Mall in Denver, Colorado. The claimant described the steering on the mall bus as being "stiff."
4. The claimant testified that the configuration of the Market Street Station required her to turn the bus to the left in order to avoid an "island" and then back to the right to avoid hitting the rear wheels on the curb. The claimant stated that as she turned to the left her right wrist "popped." The claimant did not immediately notice any pain in her wrist.
5. The claimant worked a split shift on June 30, 2008. The claimant completed her first shift at approximately 8:30 a.m. and then drove home. She did not notice any pain at this time. The claimant then returned to work at approximately 12:30 p.m. and began driving a different route. The claimant testified that she first noticed slight wrist pain when she arrived for the afternoon shift, and the pain worsened when she began driving her route. The pain became severe enough that the claimant determined she could not complete the shift and notified the dispatcher that she needed a replacement driver.
6. The claimant filed a written report of injury with a supervisor on June 30, 2008. The written report stated that her wrist popped when she turned to avoid the curb then "turned again."
7. The employer referred the claimant to OccMed Colorado for treatment. On July 1, 2008, Monica Fanning N.P.-C examined the claimant. The claimant gave a history that her wrist "popped" when she turned the steering wheel "clockwise." The claimant further stated that she first experienced pain and numbness in her hand when she began driving her afternoon route. NP Fanning noted that there was no significant swelling or discoloration, but there was "dorsoradial wrist pain extending into the base of the thumb." NP Fanning assessed a right wrist strain and imposed restrictions of no gripping with the right hand and no lifting in excess of 10 pounds. NP Fanning noted the "objective findings" were "consistent with history and/or work related mechanism of injury/illness."
8. On July 10, 2008, the claimant returned to OccMed and Dr. J. Raschbacher, M.D., examined her. The claimant reported that her wrist symptoms were better with no burning, tingling or numbness. Dr. Raschbacher released the claimant to return to duty with no restrictions.
9. On July 16, 2008, NP Fanning examined the claimant. The claimant reported pain of 10 on scale of 10 after she returned to work. NP Fanning noted the pain was at the ulnar side of the wrist, although it was on the radial side at the initial evaluation. There was no significant swelling or discoloration. NP Fanning prescribed hand therapy to address the claimant's symptoms. No restrictions were imposed.
10. On July 17, 2008, Dr. Raschbacher referred the claimant to Dr. Roth for a "causation analysis" and medical management. Dr. Roth examined the claimant on July 28, 2008. The claimant reported "circumferential" discomfort of the right wrist, although she was reportedly "better than when symptoms first began." Dr. Roth assessed a "right wrist strain" by history and "latent carpal tunnel syndrome." Dr. Roth opined the etiology of the right wrist symptoms was "not clear," and that no definitive causation analysis

could be made “in the absence of a medically probable diagnosis.” Dr. Roth noted a “disconnect” between the “work event/moment” and the onset of the wrist symptoms.”

11. On August 14, 2008, the claimant suffered another incident at work. The claimant injured her right upper extremity when she reached out to push herself away from a driverless bus that was rolling in her direction. The claimant testified that she “jammed” her arm and experienced pain all the way from the right wrist up through her shoulder and into her neck.

12. Dr. Roth examined the claimant on August 15, 2004. Dr. Roth testified that when the claimant reported that she reached out with her right arm to push away from the bus. Dr. Roth testified the claimant reported severe right wrist pain, and that he observed the wrist to be swollen. Dr. Roth arranged for the claimant to be seen by a hand surgeon.

13. Dr. Sean Griggs, M.D., of Hand Surgery Associates examined the claimant on August 15, 2008. Dr. Griggs noted a history that the claimant experienced a “pop” in her wrist on June 30, 2008, and experienced a second injury on August 14, 2008, when she put her hand out to brace against a bus. Dr. Griggs assessed a wrist sprain and reactive carpal tunnel syndrome. He imposed restrictions of no lifting in excess of 10 pounds, and recommended the claimant wear a splint.

14. The claimant underwent physical therapy (PT) following the August 14, 2008, injury. In addition to her right wrist pain, the claimant reported to the therapist that she was experiencing right upper arm pain and right posterior upper quadrant pain.

15. Dr. Roth examined the claimant on October 2, 2008. The claimant reported her wrist discomfort decreasing and her symptoms were minimal. Dr. Roth noted the claimant was continuing to complain of right upper quarter and arm pain that started a “few days after the 8/14/08 event.” On October 6, 2008, Dr. Roth performed a right AC joint injection. On October 13, 2008, Dr. Roth reported the claimant received some relief from the AC injections, but the right cervical, trapezius and periscapular myofascial discomfort persisted.

16. On December 10, 2008, Dr. Roth reported the claimant had no right wrist symptoms, and the June 30, 2008, wrist sprain was resolved.

17. On January 12, 2009, Dr. Roth wrote a letter to the insurer. Dr. Roth stated that he treated both the June 30, 2008, injury and the August 14, 2008, injury. Dr. Roth explained that he considered the August 14 injury as a “supervening event” that “replaced” the June 30, 2008 injury. Dr. Roth explained that each event resulted in the “same similar symptoms and the same body part was involved.” Dr. Roth further stated that he placed the claimant at maximum medical improvement (MMI) for both of these injuries on November 3, 2008. Finally, Dr. Roth stated that he was unable to “say definitively whether the symptoms at the time of initial evaluation were or were not caused by events described by [the claimant] as occurring on” June 30, 2008. This was true because determination of the cause of the June 30, 2008, would have been based on the claimant’s clinical course, but the clinical investigation was interrupted by the August 14 injury.

18. On April 14, 2009, Dr. John S. Hughes, M.D., performed an independent medical examination (IME) at the claimant’s request. Dr. Hughes took a history from the claimant, conducted a physical examination and reviewed medical records concerning the claimant’s various injuries.

19. On April 15, 2008, Dr. Hughes issued a report detailing his findings and opinions. Dr. Hughes assessed a "right wrist sprain" on June 30, 2008, which was aggravated by the injury of August 14, 2008. Dr. Hughes opined the wrist injuries had resolved because the claimant's wrist was asymptomatic on the date of the IME.

20. The claimant proved it is more probably true than not that she sustained an injury to her right wrist arising out of and in the course of her employment on June 30, 2008, when she turned the wheel of the bus. The ALJ credits the claimant's testimony that she experienced a "pop" in the right wrist when she turned the wheel of the bus, and that later in the day she experienced severe right wrist pain when she resumed her duties driving the bus. The ALJ finds the claimant's testimony, with a few minor exceptions, is consistent with and corroborated by the written report that she made to her supervisor on June 30, 2008, and the history she gave to NP Fanning on July 1, 2008.

21. The claimant also proved it is more probably true than not that the June 30, 2008 incident proximately caused a wrist sprain that necessitated medical treatment commencing on July 1, 2008, when she visited OccMed. The ALJ credits NP Fanning's diagnosis that the claimant presented with evidence of a sprained wrist sprain and that her observations were consistent with a work related mechanism of injury. NP Fanning prescribed treatment and imposed restrictions. NP Fanning's conclusions are corroborated by the credible opinion of Dr. Hughes, who reviewed the pertinent medical records and also opined the claimant sustained a right wrist strain on June 30, 2008.

22. Insofar as Dr. Roth opined that he is unable to state that the claimant sustained a right wrist strain on June 30, 2008, the ALJ finds that his opinion is not entitled to as much weight as those expressed by NP Fanning and Dr. Hughes. Dr. Roth's opinion is based on the "disconnect" between the "pop" in the claimant's wrist and the onset of symptoms, the absence of a "specific diagnosis," and the intervention of the August 14, 2008 injury. However, the ALJ finds that Dr. Roth did not examine the claimant until July 28, 2008, nearly one month after the date of the alleged injury. In these circumstances Dr. Roth was not in as good a position as NP Fanning to determine whether or not the claimant sustained a wrist strain caused by the performance of her duties. Further, Dr. Hughes reviewed NP Fanning's notes and opined the claimant sustained a wrist strain on June 30, 2008. Consequently, the ALJ infers that Dr. Hughes was aware of the relatively brief delay between the "pop" and the onset of wrist symptoms, but concluded that this delay was not decisive in diagnosing the injury and arriving at an opinion concerning causation. Finally, Dr. Roth does not rule out the possibility that the claimant sustained a wrist injury. Instead, he merely states that his causation analysis was truncated by the intervention of the August 14, 2008, injury.

23. The ALJ infers from the medical records that the treatment the claimant was provided after June 30, 2008, and prior to being placed at MMI on November 3, 2008, was reasonable and necessary to treat the claimant's injury of June 30. The ALJ infers that the physicians treating the claimant, including Dr. Raschbacher, Dr. Roth, and Dr. Griggs, would not prescribe treatments and tests that they considered unnecessary and unreasonable. Moreover, the ALJ finds that the injury of June 30, 2008, was a significant factor in the need for treatment despite the intervening injury of August 14, 2008. As Dr. Roth explained, after August 14 he was treating symptoms that were similar to those he treated before that date, and he was also treating the same body parts (including right wrist) after August 14. Moreover, he placed the claimant at MMI for the June 30, 2008,

injury on November 3, 2008, the same date as he placed the claimant at MMI for the August 14, 2008, injury.

24. The claimant testified that on December 13, 2003, she was assigned to drive a bus to the airport. This job required the claimant to lift luggage on and off of the bus. The claimant stated that on December 13 she lifted some heavy luggage onto the bus and then experienced burning pain in her right forearm beneath the elbow. The claimant called dispatch for a relief driver and then sought treatment at Beacon Medical Services (Beacon). The claimant testified that she first noticed this type of pain when she was lifting a lot of luggage around the Thanksgiving holiday, but the events of December 13 "put it over the top."

25. The claimant reported to Beacon on December 13, 2008, and was examined and treated by P.A. Sara Stout. Dr. Thomas Dietrich, D.O. supervised P.A. Stout and discussed the case with her. The claimant gave a history of pain in the right arm, the right elbow and the right forearm, and stated the pain was worse when "lifting objects." However, there is no specific mention of lifting luggage at work as a cause of her symptoms. Instead, the claimant advised that she experienced an injury when hit by a bus in August 2008, and that her pain began 4 months ago. P.A. Stout noted mild tenderness in the right anterior elbow, and mild tenderness in the mid ulnar aspect of the forearm. P.A. Stout's clinical impressions were "chronic upper extremity pain involving right elbow" and "strained right upper arm." The claimant was given a prescription for Vicodin and Valium and restricted to lifting no more than 5 pounds for 1 week.

26. The claimant returned to Dr. Roth on December 18, 2008. The claimant gave a history that on December 13, 2008, she awakened from sleep with severe right lateral elbow pain and went to the emergency room. The claimant reported that she had not worked since visiting the emergency room. Upon examination Dr. Roth noted "mild myofascial irritability at the trapezius and levator." He also noted "typical epicondylar tenderness." Dr. Roth wrote that it appeared the claimant was suffering from lateral epicondylitis that represented a "new cumulative trauma upper extremity disorder." Dr. Roth opined that the claimant was small and deconditioned and "luggage handling may no longer be appropriate." Dr. Roth referred the claimant for an evaluation by Dr. Mordick.

27. Dr. Mordick examined the claimant on January 6, 2009. The claimant advised Dr. Mordick that she began to experience elbow pain in November after she returned to work. The claimant could not recall any "inciting event or injury" but attributed the pain to lifting bags onto buses during the "holiday season rush." The claimant also questioned whether there was some shoulder involvement. Dr. Mordick diagnosed likely epicondylitis and referred the claimant for therapy. Dr. Mordick also referred the claimant to Dr. Griggs to assess the "shoulder issues."

28. On January 9, 2009, Dr. Roth reviewed Dr. Mordick's report and the December 13, 2008, emergency room report and cancelled the referral to Dr. Griggs. Dr. Roth noted that the "shoulder complaints are new."

29. Dr. Roth again examined the claimant on January 12, 2009. Dr. Roth noted "upper torso irritability," AC joint tenderness and lateral epicondylitis. Dr. Roth wrote that the claimant's "myofascial proclivity" is not work related in light of the persistence of symptoms over time while off duty, and that her history was not consistent with a right shoulder injury on June 30, 2008, August 14, 2008, or December 13, 2008. Dr. Roth questioned the work relatedness of the epicondylitis, and stated he suspected it was "part

and parcel of right upper quarter, and right upper extremity trigger point proclivity." Dr. Roth also noted there was an independent question of the claimant's "fitness for duty" involving baggage handling considering the claimant's "natural inherent physical limitations."

30. Dr. Roth examined the claimant on January 19, 2009. Dr. Roth reiterated that the claimant's "myofascial proclivity" was not work related, and that her history was not consistent with a shoulder injury. Dr. Roth also expressed uncertainty as to the etiology of the epicondylitis. Dr. Roth stated, "epicondylitis is a frequent concomitant of trigger point associated with upper quarter myofascial activity."

31. Dr. Roth again examined the claimant on February 9, 2009. At that time the claimant reported that her symptoms, including those related to lateral epicondylitis, were resolved. Dr. Roth assessed the claimant with "right lateral epicondylitis – resolved," and pronounced the claimant at MMI without restrictions. However, Dr. Roth opined that repetitive heavy materials handling is not an appropriate activity for the claimant and she is restricted from baggage handling activities.

32. Dr. Roth testified that when he examined the claimant on December 18, 2008, she reported symptoms of elbow pain that awakened her on December 13, and did not report any new event." The claimant did not report any other symptoms at that time. Dr. Roth further stated the claimant did not provide any history that lifting luggage increased her pain.

33. Dr. Roth opined the claimant suffers from a proclivity to experience "regional discomfort" in the right upper quarter that cannot be explained as a distinct injury or a cumulative trauma disorder. In this regard Dr. Roth noted he had been treating the claimant for various upper extremity complaints since 2007, when she had the trigger finger problem.

34. In the IME report of April 15, 2008, Dr. Hughes recorded that the claimant was reporting symptoms of "burning" type pain in her right neck and shoulder. The claimant also reported "burning and stabbing" pain in the lateral right elbow that was worse than the shoulder and neck pain. Dr. Hughes stated that he agreed with Dr. Roth that the claimant is "hypersensitive to developing upper extremity enthesopathies in response to material handling and other upper extremity use." However, Dr. Hughes also assessed the "gradual onset of right lateral epicondylitis, probably accelerated by handling luggage meriting further evaluation and treatment." Dr. Hughes further assessed a right shoulder sprain/strain on August 14, 2008, with a "subsequent aggravation occurring as a result of handling luggage during December with current findings consistent with an internal derangement of unknown type." Dr. Hughes also noted the existence of right AC joint arthritis. Dr. Hughes opined the claimant is not at MMI for these conditions because she needs a non-contrast MRI of the right shoulder and the right elbow, and an orthopedic consultation.

35. The claimant failed to prove it is more probably true than not that she sustained an injury or occupational disease, affecting her right upper extremity and cervical region, that was proximately caused, aggravated or accelerated by the performance of her duties as a bus driver. First, the claimant's testimony that her elbow and right upper extremity problems began while lifting luggage on the airport run is not credible and persuasive. The claimant's testimony that she experienced the onset of elbow pain sometime in November 2008 while lifting luggage on the bus run, and that this problem be-

came unbearable on December 13, 2008, is not credible and persuasive. The claimant's testimony is contradicted by the emergency room report of December 13, 2008. On December 13 the claimant gave a history that her right upper extremity symptoms began four months ago, and became "worse recently." Although the emergency room records mention that symptoms increase when lifting objects, there is no mention of "lifting luggage" over the holiday season, nor is there any mention of a specific lifting incident on December 13. When the claimant saw Dr. Roth on December 18, 2008, she did not describe any new event, or any problem lifting baggage on December 13. Rather, she told Dr. Roth that she had awakened with elbow pain on December 13 and sought treatment. The first appearance in the medical records of any specific history by the claimant that her upper extremity problems were caused by lifting baggage occurs in Dr. Mordick's report of January 6, 2009.

36. Dr. Roth credibly opined that he believes the epicondylitis represents the claimant's natural proclivity to experience right upper quarter and right upper extremity problems rather than a "cumulative trauma" problem. As noted by Dr. Roth, the claimant did not report to him on December 18, 2008, that she believed lifting luggage was the cause of her symptoms. Rather, she simply stated that on December 13 she woke up with the elbow problem and sought treatment. Moreover, as Dr. Roth pointed out, the epicondylitis appeared in the context of the claimant having experienced several other right upper quarter symptoms. However, the ALJ finds it significant that the claimant did not report any shoulder pain to Dr. Roth on December 18, 2008, and did not raise any right shoulder issue until she saw Dr. Mordick on January 6, 2009. The report to Dr. Mordick occurred almost three weeks after the claimant left work on December 13, 2009, lending credibility to Dr. Roth's opinion that the claimant may suddenly experience right upper quarter symptoms without explanation and without any immediate temporal relationship to the duties of her employment.

37. The opinion of Dr. Hughes that the right epicondylitis was "accelerated" by the performance of her duties lifting baggage is not credible and persuasive. Although Dr. Hughes opines the claimant's epicondylitis was probably accelerated by baggage handling, he does not explain why she did not report an association between baggage handling and her symptoms to the emergency room on December 13, 2008, or to Dr. Roth on December 18, 2008. Neither does Dr. Hughes offer any persuasive medical explanation of how epicondylitis can be "accelerated" by baggage handling. Moreover, Dr. Hughes appears to agree with Dr. Roth that lateral epicondylitis can develop independent of work, and that the claimant is "hypersensitive" to developing upper extremity problems.

38. The opinion of Dr. Hughes that the claimant sustained an "aggravation" of her right shoulder strain as a result of handling baggage is not persuasive. Dr. Hughes does not identify the specific "aggravation," but describes it as "unknown." Neither does Dr. Hughes explain why the claimant delayed almost three weeks after she stopped working on December 13, 2008, to complain to Dr. Mordick about shoulder symptoms associated with baggage handling.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the ALJ draws the following conclusions of law:

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents. Section 8-43-201.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

COMPENSABILITY OF JUNE 30, 2008 INJURY

The claimant alleges she sustained a compensable wrist injury on June 30, 2008, when she turned the bus. The ALJ agrees.

The claimant was required to prove by a preponderance of the evidence that the conditions for which she seeks medical treatment were proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(c), C.R.S. An injury occurs "in the course of" employment where the claimant demonstrates that the injury occurred within the time and place limits of her employment and during an activity that had some connection with her work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The "arising out of " element is narrower and requires claimant to show a causal connection between the employment and the injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *See Triad Painting Co. v. Blair*, *supra.* The mere fact that an injury occurs at work does not establish the requisite causal relationship to demonstrate that the injury arose out of the employment. *Finn v. Industrial Commission,* 165 Colo. 106, 437 P.2d 542 (1968).

Further, the claimant must prove a causal nexus between the claimed disability and the work-related injury. *Singleton v. Kenya Corp.,* 961 P.2d 571 (Colo. App. 1998). A pre-existing disease or susceptibility to injury does not disqualify a claim if the employ-

ment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). However, the mere occurrence of symptoms at work does not require the ALJ to conclude that the duties of employment caused the symptoms, or that the employment aggravated or accelerated any pre-existing condition. Rather, the occurrence of symptoms at work may represent the result of or natural progression of a pre-existing condition that is unrelated to the employment. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1995); *Cotts v. Exempla, Inc.,* W.C. No. 4-606-563 (August 18, 2005). The question of whether the claimant met the burden of proof to establish the requisite causal connection is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

The claimant must prove causation to a reasonable probability. Lay testimony alone may be sufficient to prove causation. However, where expert testimony is presented on the issue of causation it is for the ALJ to determine the weight and credibility to be assigned such evidence. *Rockwell International v. Turnbull,* 802 P.2d 1182 (Colo. App. 1990).

As determined in Finding of Fact 20 and 21 the claimant proved it is more probably true than not that on June 30, 2008, she sustained an injury to her right wrist that was proximately caused by an injury arising out of an in the course of her employment. As found, the ALJ credits the claimant's testimony that her right wrist popped when turning a bus during the course of her regular duties as a driver. That same afternoon she experienced severe right wrist symptoms that rendered her unable to complete her shift. On July 1, 2008, NP Fanning diagnosed her with a wrist sprain consistent with a work related mechanism of injury. Dr. Hughes credibly corroborates NP Fanning's diagnosis of a work related strain. Moreover, for the reasons stated in Finding of Fact 22, the ALJ has determined that Dr. Roth's opinion that he is unable to determine whether there was a work related injury on June 30, 2008, is not persuasive.

COMPENSABLITY OF MEDICAL TREATMENT FOR INJURY OF JUNE 30, 2008

The claimant seeks an award of medical benefits attributable to the injury of June 30, 2008. In particular, the claimant seeks an order requiring the respondent to pay for the treatment rendered by Dr. Roth commencing July 28, 2008, and continuing.

Respondents are liable to provide medical treatment that is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. 2005. The question of whether the claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

The claimant must also prove a causal nexus between the claimed need for medical treatment and the work-related injury. *Singleton v. Kenya Corp.,* 961 P.2d 571 (Colo. App. 1998). However, no compensability exists if the disability and need for

treatment was caused as the direct result of an independent intervening cause. *Owens v. Industrial Claim Appeals Office,* 49 P.3d 1187 (Colo. App. 2002). The question of whether the disability and need for medical treatment was caused by the industrial injury or an intervening cause is a question of fact. *Owens v. Industrial Claim Appeals Office, supra.*

As determined in Finding of Fact 23, the ALJ infers that the treatment the claimant received from July 1, 2008, through until November 3, 2008, was reasonable and necessary to treat the effects of the June 30, 2008, injury. Moreover, the ALJ infers from the reports and testimony of Dr. Roth that the need for the treatment was to a significant degree related to symptoms stemming from the June 30, 2008, injury.

COMPENSABILITY OF ALLEGED OCCUPATIONAL DISEASE

The claimant alleges that lifting luggage over the holiday season caused her to develop right upper extremity problems that comprise a distinct “industrial injury.” The ALJ concludes that the claimant has failed to prove either a disease or a traumatic injury affecting her right upper extremity and cervical region.

The test for distinguishing between an accidental injury and occupational disease is whether the injury can be traced to a particular time, place, and cause. *Campbell v. IBM Corporation,* 867 P.2d 77 (Colo. App. 1993). "Occupational disease" is defined by § 8-40-201(14), C.R.S., as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

This section imposes additional proof requirements beyond those required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). However, the existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.*

The claimant bears the burden to prove by a preponderance of the evidence that the hazards of the employment caused, intensified or aggravated the disease for which compensation is sought. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000); *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251

(Colo. App. 1999). The question of whether the claimant has proven causation is one of fact for the ALJ. *Faulkner v. Industrial Claim Appeals Office, supra*. In this regard the mere occurrence of symptoms in the workplace does not require the conclusion that the conditions of the employment were the cause of the symptoms, or that such symptoms represent an aggravation of a preexisting condition. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1985); *Cotts v. Exempla, Inc.,* W.C. No. 4-606-563 (I.C.A.O. August 18, 2005). Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

The ALJ concludes the claimant failed to prove that her upper extremity elbow, shoulder and neck problems were the result of an accidental injury traceable to a particular time place or cause. Rather, the claimant's own testimony is that her elbow problems, and later her shoulder problems, developed during the holiday season of 2008 when she was required to lift baggage and put it on the bus. The claimant testified that the alleged incident of December 13, 2008, put her "over the top," but does not argue that this incident constituted an injury in and of itself. In these circumstances the ALJ concludes the claimant is alleging she sustained an occupational disease as that term is defined by § 8-40-201(14).

The ALJ concludes, as determined in Findings of Fact 35 through 38 that the claimant failed to prove she sustained any occupational disease that was proximately caused, aggravated or accelerated by the "hazards" of her employment. The claimant's testimony that she developed elbow symptoms that she associated with lifting baggage is not credible. As found, that testimony is inconsistent with the history the claimant gave at the emergency room on December 13, 2008, as well as the history she gave to Dr. Roth on December 18, 2008. The ALJ is persuaded by Dr. Roth's opinion that the epicondylitis is a product of the claimant's proclivity to develop various right upper quarter and extremity complaints not associated with "cumulative trauma" or other work related causes. Indeed, the claimant reported to Dr. Roth that the epicondylitis awakened her from sleep, not that she experienced pain while lifting baggage on December 13, 2008, or during the 2008 holiday season. Moreover, the claimant failed to prove that her shoulder pain was caused, aggravated or accelerated by lifting bags. The claimant did not report shoulder symptoms until nearly three weeks after she was taken off work on December 13, 2008. The opinion of Dr. Hughes opinion that lifting bags "aggravated" a shoulder injury that occurred on August 14, 2008, is not credible. Dr. Hughes did not explain what aggravation occurred or provide any persuasive explanation of the mechanism of aggravation. Neither did Dr. Hughes offer a persuasive explanation for the claimant's delay in reporting the shoulder symptoms.

For these reasons the claim for workers' compensation benefits in WC 4-780-145 is denied and dismissed. In light of this determination the ALJ need not address issues concerning temporary disability and medical benefits attributable to the alleged injury.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The claimant sustained a compensable injury in WC 4-764-458.

2. The employer shall pay reasonable and necessary medical benefits as a result of the compensable injury in WC 4-764-458. Specifically the respondents shall pay for the treatments provided by OccMed, Dr. Roth, and Dr. Griggs prior to the time the claimant reached MMI for this injury on November 3, 2008.

3. The claim for workers' compensation benefits in WC 4-780-145 is denied and dismissed.

4. All matters not determined herein are reserved for future determination.

DATED: October 6, 2009

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-789-310

ISSUES

The issue presented for consideration at hearing is whether Claimant suffered a compensable injury.

FINDINGS OF FACT

Having considered the evidence presented at hearing and the parties' post hearing position statements, the following Findings of Fact are entered.

1. Claimant, whose date of birth is September 28, 1968, was working for the Employer in December 2008, as an Administrative Assistant. Claimant is paid by the hour. Her job duties include data entry and customer service. Claimant also assists her boss, Manuel Bernal, in the scheduling of construction crews.

2. On December 13, 2008, Claimant was injured when she retrieved a shed that was no longer wanted by a customer. The customer offered to give the shed to Claimant at not cost. Claimant was only required to take the shed away from the property where it was located. The shed was owned by a customer who purchased the shed four or five years ago, and wanted to have it removed. Claimant became aware of the customer's offer through a communication from her boss, Mr. Bernal, the General Manager.

3. Claimant testified that she learned that Mr. Bernal received a call from a customer who asked to have a previously purchased shed removed from his property. The

customer was advised that the Employer was not in the business of removing previously purchased sheds, as they only sell new sheds. Claimant also recalls that in November 2008, Mr. Bernal, offered a “free” shed to any employee who wanted to retrieve it. Claimant testified that she was aware that a co-employee indicated that he would like the shed.

4. Mr. Bernal testified that he received a call from a customer requesting that the Employer arrange for the removal of a shed previously purchased from the Employer. Mr. Bernal advised the customer that the Employer is not in the business of removing sheds and that removal of a shed is the customer’s responsibility. Mr. Bernal further testified that the customer offered to give the shed to anyone interested in dismantling the shed and removing it from his property. Mr. Bernal relayed the customer’s offer to his employees. One of Claimant’s co-workers’s indicated a willingness to take the shed and the customer was so advised. However, in mid-November 2008, Mr. Bernal learned when the customer called again that the shed was not removed and Claimant’s co-worker had changed his mind about taking the shed. Mr. Bernal told the customer that he would see if anyone else was interested in the shed, and Claimant indicated that she would take it.

5. Claimant advised Mr. Bernal that she would check with her boyfriend; and after so doing, she advised Mr. Bernal that she wanted the shed. Mr. Bernal testified that he gave Claimant the customer’s paperwork, and told her to contact the customer to arrange for the removal of the shed. Mr. Bernal had no further contact with the customer or Claimant about the arrangements. Claimant testified that Mr. Bernal told her to take the shed down immediately. In contrast to this testimony, Mr. Bernal testified credibly that he made no demands on Claimant with regards to the shed.

6. Mr. Bernal testified that it is very rare for a customer to offer to give away a shed. He noted that it has happened one time in the prior seven to eight years during his employment. He confirmed that the Employer is in the business of selling sheds and that they do not get involved in the reclamation of previously sold sheds, nor the relocation of previously sold sheds.

7. Mr. Bernal testified that Claimant’s acceptance of the “free” shed was of no benefit to the Employer. Mr. Bernal further testified that if none of his employees desired the “free” shed, he would have advised the customer of this fact, and then, it would be up to the customer to figure out what to do with the shed.

8. Mr. Bernal testified that he exercised no control over when Claimant picked up the shed, nor did he have any specific knowledge as to when this was to occur. Furthermore, he did not dispatch any other of the Employer’s employees to assist Claimant in retrieving the shed, nor did he provide Claimant with a company truck or tools to assist her in retrieving the shed. Claimant is paid by the hour and the retrieval of the shed was not part of her compensation package. Claimant retrieved the shed on Saturday, December 13, 2008, a date when she was not scheduled to work nor was she paid for work on this date.

9. Claimant credibly testified that that the shed she retrieved on December 13, 2008, was not the property of the Employer, nor did she plan on bringing it back to her employer's place of business after retrieving it. Claimant further admitted that she contacted the owner of the shed herself and made the arrangements for its removal directly with the owner. Claimant used her own truck to haul the shed away from the customer's property.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of providing entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. In Colorado, only those injuries "arising out of" and "in the course of employment," are compensable under the Workers' Compensation Act. Section 8-41-301(1), C.R.S.; *In re Question Submitted by U.S. Court of Appeals,* 759 P.2d 17 (Colo. 1988). The course of employment requirement is satisfied when the claimant shows that the injury occurred within the time and place limits of the employment. *Popovich v. Irlando,* 811 P.2d 379 (Colo. 1991). In the present case Claimant failed to establish that

her injury occurred within the time and place limits of the employment. Claimant injury occurred on a Saturday when she was not working, at the place of a former customer of the Employer, for the purpose of removing a shed for Claimant's personal use.

5. The "arising out of" element is narrower than the "course" element and requires the claimant to prove the injury had its "origin in an employee's work-related functions and is sufficiently related thereto to be considered part of the employee's service to the employer." *Supra at 383.* However, the employee's activity need not constitute a strict duty of employment or confer a specific benefit on the employer if it is incident to the conditions under which the employee usually performs the job. *City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985). *University of Denver v. Nemeth,* 127 Colo. 385, 257 P.2d 423 (1953). It is not essential that the employee is performing a mandatory act at the time of the injury. *See Employers' Mutual Ins. Co. v. Industrial Commission,* 76 Colo.84, 230 P. 394 (1924).

6. In this case, it is concluded that Claimant did not satisfy the "arising out of" element. Claimant failed to prove by a preponderance of the evidence that she conferred a benefit on the employer by removal of the shed nor did she establish that she was performing a work related function which could be considered part of the Claimant's service to the Employer. In this case, Mr. Bernal's testimony was found to be more credible and persuasive than Claimant's about whether she was ordered to remove the shed from the customer's property.

7. Since Claimant failed to establish that she suffered an injury in the course and scope of her employment for the Employer, she is not entitled to workers' compensation benefits.

ORDER

It is therefore ordered that:

Claimant's claim for workers' compensation benefits for an injury alleged to have occurred on December 13, 2008, is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: October 6, 2009

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-712-019

ISSUES

Whether Respondent is entitled to an award of penalties against Claimant's attorney under Section 8-43-304(1), C.R.S. for the failure of Claimant's attorney to comply with the Supplemental Order of ALJ Felter dated February 19, 2009 awarding Respondent attorneys fees and costs of $1,338.85 against Claimant's attorney.

At hearing, Respondent's Exhibits A through Q were admitted into evidence. Also at hearing, Claimant's attorney's unlabeled and un-paginated packet of Exhibits was admitted into evidence.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Hearing in this matter was previously held before ALJ Edwin L. Felter, Jr. on September 18, 2008. The issues at hearing included, inter alia, Claimant's challenge to the propriety of the DIME physician selection process, whether Claimant had waived her right to a DIME and Respondent's request for imposition of attorney fees and costs against Claimant's attorney.

2. Following hearing, ALJ Felter issued a Supplemental Order dated February 19, 2009. In that Order, ALJ Felter assessed attorney fees and costs of $1,338.85 against Claimant's attorney. The Supplemental Order specifically provided at paragraph D of the "ORDER";

> "The Claimant's attorney shall pay and reimburse the Respondent $1,338.85 for its attorney fees and costs, incurred in defending the 'propriety of the Division Independent Medical Examination' a second time for the hearing of September 18, 2008."

3. The Supplemental Order of ALJ Felter dated February 19, 2009 further provided at paragraph E of the "ORDER":

> "Claimant's attorney is granted a stay of 20 days from the date of this Supplemental Order within which to pay the attorney fees and costs. In the event Claimant timely files a timely Petition to Review, payment for the attorney fees and cost shall be stayed while the appeal is pending."

4. Claimant filed a Petition to Review the Supplemental Order of February 19, 2009. The Industrial Claim Appeals Office considered Claimant's appeal and issued a Final Order on June 3, 2009. The Final Order of the Industrial Claim Appeals Office affirmed the Supplemental Order as to the award and assessment of attorney fees and costs against Claimant's attorney in the amount assessed by ALJ Felter in paragraph D of the Supplemental Order of February 19, 2009.

5. Claimant's attorney admits, and it is found, that he did not timely file for review of the Industrial Claim Appeals Office Final Order of June 3, 2009 with the Court

of Appeals. Under the provisions of Sections 8-43-301(10) and 8-43-307, C.R.S. a Petition to Review was to be filed with the Court of Appeals by June 23, 2009, 20 days from the date of the Industrial Claim Appeals Office's Final Order. The Final Order of the Industrial Claim Appeals Office dated June 3, 2009 therefore became final and not subject to further review as of June 24, 2009. ALJ Felter's award of attorney fees and costs against Claimant's attorney in the Supplemental Order of February 19, 2009 therefore also became final and not subject to further review as of June 24, 2009.

6. By MoneyGram money order obtained through Safeway in the amount of $400.00 Claimant's attorney made a partial payment of the attorney fees and costs awarded by ALJ Felter on July 6, 2009. The notation made on the money order stated "Alice Rodriguez partial attorney fees". The money order was made payable to "Doug Thomas".

7. In a "Fax Cover Sheet" correspondence to Doug Thomas dated July 6, 2009 Claimant's attorney stated "Sent $400 today in partial payment of the above. Will send remainder within 2 weeks. Can't do better at this time. Sorry." Signed: Rick Blundell.

8. Claimant's attorney did not issue any further payment of the attorney fees and costs awarded by ALJ Felter until August 28, 2009. On that date, by way of MoneyGram money order obtained through Safeway, Claimant's attorney made a second partial payment of $400 for the attorney fees and costs awarded by ALJ Felter. The notation made on the money order stated "Alice Rodriguez partial attorney fees". The money order was made payable to "Doug Thomas".

9. Claimant's attorney did not issue any further payment of the attorney fees and costs awarded by ALJ Felter until September 24, 2009. On that date Claimant's attorney issued a check drawn on the General Account of Richard K. Blundell Law Firm, Check No. 16168, in the amount of $538.85 payable to Douglas A. Thomas. In the memo portion of the check was the printed language "Alice Rodriguez – Balance Attorney Fee in full". In addition to this language was the handwritten language made by Claimant's attorney "Due to Thomas' successful fraud!"

10. The award of attorney fees and costs of $1,338.85 was due and payable in full as of June 24, 2009.

11. Claimant's attorney admitted, and it is found, that during the period between February 20 and September 24, 2009 his law firm's account at times had in excess of $1,400 in the account. Claimant's attorney also admitted, and it is found, that during this period he settled workers' compensation cases for clients and collected attorney fees in excess of $1,400.

12. The period from June 24 through July 6, 2009 is period of 13 days.
13. The period from July 7 through August 28, 2009 is a period of 53 days.
14. The period from August 29 through September 23, 2009 is a period of 26 days.

15. In response to a letter from Respondent's counsel, Douglas A. Thomas, Esq. dated September 22, 2009 to Claimant's attorney concerning an application for hearing filed by Claimant's attorney in this claim claiming penalties for delayed filing of a Final Admission Claimant's attorney made the handwritten statement: "Both you & your client are established notorious liars, cheats, & frauds".

16. Claimant's attorney testified that due to personal financial and health problems he was unable to fully pay the award of attorney fees and costs assessed by ALJ Felter until September 24, 2009. The ALJ finds this testimony to be unpersuasive.

17. Claimant's attorney was not in compliance with the Supplemental Order of ALJ Felter dated February 19, 2009 directing Claimant's attorney to pay and reimburse Respondent for its attorney fees and costs in the amount of $1,338.85 as of June 24, 2009. Claimant's attorney began only partial compliance with the Order as of July 6, 2009, with further partial compliance on August 28, 2009. Claimant's attorney was not in full compliance with the Supplemental Order of ALJ Felter awarding attorney fees and costs against Claimant's attorney until September 24, 2009.

18. Claimant's attorney has failed to prove, by a preponderance of the evidence, that he had an objectively reasonable basis for his failure to fully comply with the Supplemental Order of ALJ Felter dated February 19, 2009 once that Order became final as of June 24, 2009.

CONCLUSIONS OF LAW

19. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

20. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. The party requesting imposition of a penalty bears the burden of proof. *City and County of Denver v. Indus. Claim Appeals Office,* 58 P.3d 1162 (Colo. App. 2002). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

21. Section 8-43-304(1), C.R.S., 2008, states that an insurer or self-insured employer, any officer or agent of either, any employee or any other person who "violates

any provision" of Articles 40 to 47 of Title 8 "shall . . . be punished by a fine of not more than $500.00 per day for each such offense". Section 8-43-304(1) also requires punishment when an insurer or self-insured employer "fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided or fails, neglects or refuses to obey any lawful order made by the director or panel or any judgment or decree made by any court as provided by said articles shall be subject to such order being reduced to judgment by a court of competent jurisdiction and shall also be punished by a fine of not more than five hundred dollars per day for each such offense, seventy-five percent payable to the aggrieved party and twenty-five percent to the subsequent injury fund created in section 8-46-101".

22. Under Section 8-43-304(1) penalties may be imposed when a party (1) violates any provision of the Act; (2) does any act prohibited by the Act; (3) fails or refuses to perform any duty lawfully mandated within the time prescribed by the Director or Panel; or (4) fails, neglects, or refuses to obey any lawful order of the director or Panel. *Holliday v. Bestop, Inc.,* 23 P.3d 700 (Colo. 2001). Failure to comply with a procedural rule is a failure to obey an "order" within the meaning of Section 8-43-304(1). *Pioneers Hosp. v. Indus. Claim Appeals Office,* 114 P.3d 97 (Colo. App. 2005). Section 8-43-304 is penal in nature and is to be narrowly and strictly construed. *Support, Inc. v. Indus. Claim Appeals Office,* 968 P.2d 174 (Colo. App. 1998).

23. Section 8-43-304(1) authorizes the imposition of penalties of not more than $500 per day if an insurer "fails, neglects, or refuses to obey any lawful order made by the director or panel." This provision has been construed as applying to violation of an order issued by an ALJ. *Giddings v. Industrial Claim Appeals Office,* 39 P.3d 1211 (Colo. App. 2001). An order is defined as including "any decision, finding and award, direction, rule, regulation, or other determination arrived at by the director or an administrative law judge." Section 8-40-201(15), C.R.S. Thus, an order "resolves or determines" an issue or matter in the case. *Holliday v. Bestop, Inc.,* 23 P.3d 700, 708 (Colo. 2001).

24. The imposition of penalties under Section 8-43-304(1) is a two-step process. First, it must be determined whether a party has violated the Act in some manner, failed to carry out a lawfully enjoined action, or violated an order. If a violation is found, it must then be determined if the violator acted reasonably. *See, Allison v. Indus. Claim Appeals Office,* 916 P.2d 623 (Colo. App. 1995).

25. The reasonableness of a party's action depends upon whether the actions were predicated on a rational argument based on law or fact. *Diversified Veterans Corporate Center v. Hewuse,* 942 P.2d 1312 (Colo. App. 1997). The party's actions are measured by an objective standard of reasonableness. *Jimenez v. Indus. Claim Appeals Office,* 107 P.3d 965 (Colo. App. 2003). The standard is "an objective standard measured by the reasonableness of the insurer's action and does not require knowledge that the conduct was unreasonable." *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 907 P.2d 676, (Colo. App., 1995). Whether an alleged violator's conduct was objectively reasonable is a question of fact for resolution by the ALJ. *Pioneers Hospital,* supra at 99.

26. The ALJ has discretion to assess a penalty of up to $500 per day for each day the Director's order was violated. The ALJ may consider a "wide variety of factors" in determining an appropriate penalty. *Adakai v. St. Mary Corwin Hospital,* W.C. No. 4-619-954 (I.C.A.O. May 5, 2006). However, any penalty assessed should not be excessive in the sense that it is grossly disproportionate to the conduct in question. When determining the penalty the ALJ may consider factors including the "degree of reprehensibility" of the violator's conduct, the disparity between the actual or potential harm suffered by the claimant and the award of penalties, and the difference between the penalties awarded and penalties assessed in comparable cases. *Associated Business Products v. Industrial Claim Appeals Office,* 126 P.3d 323 (Colo. App. 2005).

27. The Supplemental Order of ALJ Felter assessing attorney fees and costs against Claimant's attorney specifically held the award in abeyance pending an appeal of the Order. Therefore, the award of attorney fees and costs, and Claimant's attorney's obligation to comply with the order and pay the fees and costs, remained stayed until any appeals were no longer pending. As found, the award of fees and costs became final as of June 24, 2009 when Claimant's attorney did not pursue an appeal of the Industrial Claim Appeals Office Final Order to the Court of Appeals. At that time, no further appeals were pending and Claimant's attorney was obligated to comply with the Order and pay the award of attorney fees and costs in the Supplemental Order of February 19, 2009.

28. The Supplemental Order of ALJ Felter directed Claimant's attorney to pay and reimburse Respondent for attorney fees and costs of $1,338.85. Other than the provisions of the Order staying its effectiveness pending an appeal no other limitations or conditions were placed on payment of the awarded fees and costs. The ALJ concludes that the common meaning of the terms "shall pay and reimburse" connotes payment of the amount due when due and not periodic payments on an undefined payment schedule set at the discretion of the payer. Specifically, no part of ALJ Felter's Supplemental Order provided for Claimant's attorney to pay the awarded fees and costs in the amounts and at the times as were done by Claimant's attorney here. The ALJ concludes that the terms of ALJ Felter's Supplemental Order made the payment of the entire sum of $1,338.85 for fees and costs due once any appeals had been exhausted and the Order had become final. As found, the Order became final as of June 24, 2009 and the entire amount of $1,338.85 was due and payable on that date.

29. As found, Claimant's attorney did not comply with the Order until July 6, 2009 at which time only partial compliance was made because only a partial payment of the awarded fees and costs was made. Partial compliance continued through September 24, 2009 when the fees and costs were finally paid in full. The Supplemental Order of February 19, 2009 does not contemplate partial compliance with the award of fees and costs and as discussed does not provide for partial payments or payment on a schedule set by Claimant's attorney. The ALJ therefore concludes that Claimant's attorney was not in compliance with the Supplemental Order of February 19, 2009 until September 24, 2009 when the final payment for the balance of the fees and costs due was made.

30. As found, Claimant's attorney failed to prove that he had an objectively reasonable basis for his failure to fully comply with the Supplemental Order. Claimant's attorney argues that personal financial difficulties prevented him from having the financial resources to pay the award in full. The ALJ is not persuaded. With the initial partial payment of July 6, 2009 Claimant's attorney represented that he would pay the remaining balance within 2 weeks. Not only was the remaining balance not paid, no further payment was made until August 28, 2009, almost two months later. During this time, Claimant's attorney had in his law firm's account, an account he later used to pay a portion of the awarded fees and costs, funds sufficient to pay the entire amount of the fees and costs awarded. Further, Claimant's attorney during this time received fees from client matters sufficient to pay the entire amount of the fees and costs. Claimant's attorney's assertion that personal health matters also effected is ability to pay is not persuasive in light of the fact of the funds available in the firm account and from client fees sufficient to pay the entire amount of fees and costs owed.

31. Claimant's attorney has not shown a reasonable basis in law or fact for his failure to fully comply with the Supplemental Order. As found, the Supplemental Order did not provide for or contemplate periodic payment of the fees and costs at times determined by Claimant's attorney. The ALJ concludes that Claimant's attorney at his own discretion delayed payment of an award of fees and costs he considered distasteful.

32. In arriving at the appropriate penalty the ALJ may consider the reprehensibility of Claimant's attorney's conduct. The handwritten notation on the September 24, 2009 check in payment of the balance of the fees and costs due evidences reprehensible conduct on the part of Claimant's attorney. The implication that the award of attorney fees and costs was obtained by fraud is not only disrespectful of opposing counsel but also of the integrity of the Court as well. The statements made by Claimant's attorney in response to Respondent's counsel's September 18, 2009 letter, although not directly related to the issue of compliance with the award of fees and costs, is equally reprehensible. Rather than simply complying with the Supplemental Order by paying the amount in full when due Claimant's attorney delayed payment and has made commentary regarding the integrity and reputation of Respondent and Respondent's counsel without foundation.

33. The ALJ concludes that a penalty of $50.00 per day for the period from June 24, through July 6, 2009, a period of 13 days; $75.00 per day for the period from July 7 through August 28, 2009, a period of 53 days; and $100.00 per day for the period from August 29, 2009 through September 23, 2009, a period of 26 days, in the aggregate sum of $7,225.00 is the appropriate penalty for Claimant's attorney's violation of the Supplemental Order of February 19, 2009.

ORDER

It is therefore ordered that:

Claimant's attorney, Richard K Blundell, Esq., shall pay penalties in the aggregate amount of $7,225.00, in one lump sum, 75% payable to Respondent and 25% payable to the Subsequent Injury Fund created in Section 8-46-101, C.R.S. Said amount becomes due and payable, in full, after the expiration of 20 days from the date of this Order unless a Petition to Review is timely filed.

All matters not determined herein are reserved for future determination.

DATED: October 6, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-756-973

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that a total right knee replacement is related to her April 3, 2008 industrial injury and is reasonable and necessary to relieve the effects of the injury.

2. Whether Claimant has waived her right to a Division Independent Medical Examination (DIME).

FINDINGS OF FACT

1. Claimant worked for Employer as a nurse anesthetist. On April 3, 2008 Claimant slipped and fell on an icy, concrete walkway on Employer's premises. She landed on the anterior aspect of both knees.

2. On April 16, 2008 Claimant visited Mark S. Failinger, M.D. for an evaluation of her knees. In an April 23, 2008 letter Dr. Failinger explained that Claimant has suffered from a long history of arthritis in her knees with periodic "flare-ups" in her condition. He remarked that Claimant has suffered from severe end stage arthritis for many years and has postponed knee replacement surgery as long as possible because she wanted to continue to ski. Dr. Failinger commented that, based on her x-rays, "it is amazing that she has not had knee replacements up to this point." He remarked that knee replacement surgery was "inevitable." Dr. Failinger determined that Claimant's need for knee replacements was "not connected with her work injury, although, the time may have been altered slightly."

3. On May 8, 2008 Claimant underwent an MRI of her right knee. The MRI revealed a "[m]inimally displaced acute fracture" of the patella and "prior anterior cruciate ligament reconstruction." The MRI also reflected that Claimant suffered from "severe

tricompartmental arthrosis" that included "prominent osteophyte formation" and "chondral degeneration."

4. On May 16, 2008 Claimant visited Dennis Chang, M.D. for an evaluation. Dr. Chang reported that Claimant has suffered from chronic problems in both knees. He noted that Claimant's MRI revealed tricompartmental degenerative changes and osteophyte formation in both knees. Dr. Chang remarked that Claimant's April 3, 2008 fall may have exacerbated her right knee symptoms and recommended total knee arthroplasties. He concluded that Claimant's "current need for a knee replacement is not solely due to her recent fall, but her longstanding arthritis in both of her knees."

5. On June 27, 2008 J. Stephen Davis, M.D. conducted a records review of Claimant's medical history. He noted that Claimant has suffered a long history of degenerative arthritis in both knees. Dr. Davis determined that Claimant's need for total knee arthroplasties was reasonable, but that the need for the surgeries was "based on chronic disease and not related to the incident of April 3, 2008."

6. On July 25, 2008 Claimant visited Authorized Treating Physician (ATP) John W. Dunkle, M.D. for an examination. He recounted that Claimant had suffered bilateral knee contusions and has experienced decreased function since the April 3, 2008 incident. Dr. Dunkle determined that Claimant had reached Maximum Medical Improvement (MMI) and expected that Claimant would continue to experience "waxing and waning symptoms." He remarked that any worsening of Claimant's condition "would be attributed to the natural progression of an underlying degenerative process." Dr. Dunkle assigned Claimant 14% extremity or 6% whole person impairments for each knee. She thus suffered a total 12% whole person impairment as a result of the April 3, 2008 incident.

7. On July 31, 2008 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Dunkle's determination. On August 7, 2008 Claimant objected to the FAL and sought a DIME. The DIME was scheduled for October 24, 2008 with Mark Steinmetz, M.D.

8. On September 29, 2008 Claimant visited Christopher B. Ryan, M.D. for an independent medical examination. Dr. Ryan noted that Claimant suffers from severe osteoarthritis in both knees and would have been a candidate for total knee arthroplasties prior to her work injury. However, he explained that the April 3, 2008 incident accelerated Claimant's need for total knee replacements. Dr. Ryan concluded that "[b]ut for her work injury, [Claimant] would not have required total knee arthroplasty as urgently and as early as she did under the circumstances."

9. Claimant did not attend the October 24, 2008 DIME. The DIME was rescheduled for November 21, 2008. Claimant again cancelled the DIME and the examination was rescheduled for January 26, 2009. Claimant did not attend the January 26, 2009 examination and the matter has not been rescheduled. Claimant testified at the hearing in this matter that she cancelled the three DIME's because the DIME physician lacked sufficient paperwork in the form of medical records to evaluate her condition.

10. On August 17, 2009 the parties conducted the evidentiary deposition of Dr. Davis. Dr. Davis explained that Claimant suffered from pre-existing degenerative osteoarthritis in both knees at the time of her fall on April 3, 2008. The slip and fall did not cause the osteoarthritis but merely resulted in bruising. Dr. Davis acknowledged that Claimant required an arthroplasty or total knee replacements based on her chronic condition and that prior to the April 3, 2008 incident she was willing to tolerate her discomfort and limitations. At a certain point Claimant was no longer willing to accept her limitations and decided to pursue knee replacements. Dr. Davis thus concluded that the April 3, 2008 incident did not cause Claimant to require knee replacements.

11. On August 27, 2009 the parties conducted the evidentiary deposition of Dr. Ryan. Dr. Ryan reiterated that Claimant's April 3, 2008 slip and fall accelerated her need for knee replacement surgeries. He explained that the work incident precipitated the deterioration of Claimant's condition in terms of both pain and limitation of function. Dr. Ryan acknowledged that Claimant had suffered from severe end stage arthritis for many years and postponed knee replacement surgery because she sought to continue skiing. He also recognized that during the April 3, 2008 incident Claimant had only suffered knee contusions while the pain associated with Claimant's end stage arthritis was deep within her knee.

12. Claimant has failed to demonstrate that it is more probably true than not that a total right knee replacement is related to her April 3, 2008 industrial injury and is reasonable and necessary to relieve the effects of the injury. The persuasive weight of the medical evidence reveals that the slip and fall did not aggravate, accelerate or combine with Claimant's pre-existing condition to cause the need for total knee arthroplasty. Instead, the natural progression of Claimant's underlying degenerative osteoarthritis caused her to need a total knee replacement.

13. On April 3, 2008 Claimant slipped and fell on Employer's concrete walkway. The incident resulted in superficial knee contusions. The record reveals that Claimant had suffered a long history of severe end stage osteoarthritis in both knees. Dr. Failinger remarked that Claimant had postponed knee replacement surgery as long as possible because she wanted to continue to ski. He noted that knee replacement surgery was inevitable. Dr. Chang explained that Claimant's April 3, 2008 fall may have exacerbated her right knee symptoms but her current need for a knee replacement was due to her longstanding arthritis in both of her knees. Dr. Dunkle commented that Claimant had experienced decreased function since the April 3, 2008 incident but attributed the worsening of Claimant's condition to the natural progression of an underlying degenerative process. Finally, Dr. Davis explained that Claimant's degenerative osteoarthritis reached a point at which she was no longer willing to tolerate the discomfort and limitations associated with her condition. Therefore, the April 3, 2008 incident was not the cause of Claimant's need for a knee replacement. Although Dr. Ryan opined that Claimant's slip and fall accelerated her need for a total knee replacement, he acknowledged that she had suffered from severe end stage osteoarthritis for a number of years and had postponed knee replacement surgery so that she could continue skiing.

14. The record reveals that Claimant's conduct resulted in an implied waiver of her right to a DIME. Claimant did not attend her original DIME appointment scheduled for October 24, 2008. The DIME was rescheduled for November 21, 2008. Claimant again cancelled the DIME and the examination was rescheduled for January 26, 2009. She did not attend the January 26, 2009 examination. Claimant has not subsequently rescheduled the DIME. She testified that she cancelled the three DIME's because the DIME physician lacked sufficient paperwork in the form of medical records to evaluate her condition. Claimant's explanation for her failure to attend the DIME's does not constitute persuasive evidence for her actions. Moreover, her subsequent failure to pursue the DIME is inconsistent with the assertion of her right to a DIME.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Medical Benefits

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). Nevertheless, the claimant bears the burden of demonstrating a causal connection between a work-related injury and the condition for which benefits are sought. *In Re Abeyta,* W.C. No. 4-669-654 (ICAP, Jan. 28, 2008). A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or

combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). When a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005). Furthermore, the determination of whether medical treatment is necessitated by a compensable aggravation or a mere worsening of a pre-existing condition is a question of fact for the ALJ. *In Re Abeyta,* W.C. No. 4-669-654 (ICAP, Jan. 28, 2008). When the record contains conflicting expert opinions the ALJ is charged with resolving the conflict. *Id.*

5. As found, Claimant has failed to demonstrate by a preponderance of the evidence that a total right knee replacement is related to her April 3, 2008 industrial injury and is reasonable and necessary to relieve the effects of the injury. The persuasive weight of the medical evidence reveals that the slip and fall did not aggravate, accelerate or combine with Claimant's pre-existing condition to cause the need for total knee arthroplasty. Instead, the natural progression of Claimant's underlying degenerative osteoarthritis caused her to need a total knee replacement.

6. As found, on April 3, 2008 Claimant slipped and fell on Employer's concrete walkway. The incident resulted in superficial knee contusions. The record reveals that Claimant had suffered a long history of severe end stage osteoarthritis in both knees. Dr. Failinger remarked that Claimant had postponed knee replacement surgery as long as possible because she wanted to continue to ski. He noted that knee replacement surgery was inevitable. Dr. Chang explained that Claimant's April 3, 2008 fall may have exacerbated her right knee symptoms but her current need for a knee replacement was due to her longstanding arthritis in both of her knees. Dr. Dunkle commented that Claimant had experienced decreased function since the April 3, 2008 incident but attributed the worsening of Claimant's condition to the natural progression of an underlying degenerative process. Finally, Dr. Davis explained that Claimant's degenerative osteoarthritis reached a point at which she was no longer willing to tolerate the discomfort and limitations associated with her condition. Therefore, the April 3, 2008 incident was not the cause of Claimant's need for a knee replacement. Although Dr. Ryan opined that Claimant's slip and fall accelerated her need for a total knee replacement, he acknowledged that she had suffered from severe end stage osteoarthritis for a number of years and had postponed knee replacement surgery so that she could continue skiing.

Waiver of DIME

7. Waiver is the intentional relinquishment of a known right and may be express or implied. *Rodriguez v. Safeway Stores, Inc.,* W.C. No. 4-719-019 (ICAP, June 3, 2009). Implied waiver exists "when a party engages in conduct which manifests an intent to relinquish the right or acts inconsistently with its assertion." *Burlington Northern R. Co. v. Stone Container Corp.,* 934 P.2d 902 (Colo. App. 1997). To constitute an implied waiver a party's conduct "must be free from ambiguity and clearly manifest the in-

tent not to assert the benefit." *Department of Health v. Donahue*, 690 P.2d 243 (Colo. 1984). The existence of waiver is a factual matter for determination by the ALJ. *Rodriguez v. Safeway Stores, Inc.,* W.C. No. 4-719-019 (ICAP, June 3, 2009).

8. In *Rodriguez v. Safeway Stores, Inc.,* W.C. No. 4-719-019 (ICAP, June 3, 2009), ICAP cited WCRP 11-3(H) and noted that a failure to make a DIME appointment within a specified time period could result in a cancellation of the DIME absent good cause shown. The ICAP concluded that the claimant's failure to schedule a DIME from the period August 27, 2007 until the date of the hearing on September 18, 2008 resulted in a waiver of the DIME.

9. As found, the record reveals that Claimant's conduct resulted in an implied waiver of her right to a DIME. Claimant did not attend her original DIME appointment scheduled for October 24, 2008. The DIME was rescheduled for November 21, 2008. Claimant again cancelled the DIME and the examination was rescheduled for January 26, 2009. She did not attend the January 26, 2009 examination. Claimant has not subsequently rescheduled the DIME. She testified that she cancelled the three DIME's because the DIME physician lacked sufficient paperwork in the form of medical records to evaluate her condition. Claimant's explanation for her failure to attend the DIME's does not constitute persuasive evidence for her actions. Moreover, her subsequent failure to pursue the DIME is inconsistent with the assertion of her right to a DIME.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's total right knee replacement surgery is not related to her April 3, 2008 industrial injury and is not reasonable and necessary to relieve the effects of the injury.

2. Claimant has waived her right to a DIME.

3. All issues not resolved in this Order are reserved for future determination.

DATED: October 6, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-781-435

ISSUES

The issues determined herein are compensability and temporary total disability ("TTD") benefits. The parties stipulated that treatment by Dr. Schwender was authorized and reasonably necessary.

FINDINGS OF FACT

1. Claimant worked as a mechanic for the employer between August 28, 2006 and December 16, 2008. As a mechanic, claimant performed repair and maintenance for equipment used by the employer in its large landscape material business. Claimant was supervised by Mr. Yauger. The employer has a safety program for employees supervised by Mr. Schade.

2. On approximately Friday, November 21, 2008, while repairing an axle and hub for a backhoe, claimant suffered an accidental injury to his left knee. The front axle had been pulled out and was on jack stands and claimant was reassembling the gears when he sustained an injury to his left knee. Claimant was holding the gear assembly between his legs while bending at the knee and trying to fit the gear onto the axle.

3. On November 24, 2008, claimant returned to his regular duty work for the employer. Claimant alleges that he reported his injury to Mr. Yauger, who questioned him about his limp. Mr. Yauger admitted that he saw claimant limp, but claimant did not report a work injury and merely asked for a recommendation for a physician, Dr. Brassfield.

4. On November 26, 2008, Dr. Brassfield examined claimant, who reported that he had a 10-day history of left knee pain that started when he was picking up a heavy engine housing.

5. Mr. Schade also admitted that he saw claimant limp and asked claimant about it. He testified that claimant reported that he "tweaked" his knee when he stood up and it popped. Claimant told him that he was seeing a physician about it, but he did not report a work injury.

6. On December 15, 2008, Mr. Yauger decided to terminate claimant's employment due to poor performance on a May 2008 engine repair. Mr. Yauger did not yet know about claimant's work injury. On December 16, 2008, Mr. Yauger informed claimant that his employment was terminated. Claimant then reported his left knee work injury working on a backhoe. Claimant was referred to Dr. Schwender.

7. On December 18, 2008, Dr. Schwender examined claimant, who reported that he was injured one week before Thanksgiving while kneeling to install a hub cover on the axle of a back hoe. As he was kneeling down, he felt a pain on the medial aspect of his left knee. Dr. Schwender diagnosed a left medial collateral ligament ("MCL") strain. He referred claimant for physical therapy, prescribed over-the-counter ibuprofen, and released claimant to return to regular duty work with no restrictions.

8. Claimant admitted that he physically could have continued regular duty work after December 16, 2008, but for his termination from employment.

9. On approximately April 1, 2009, claimant returned to work as a mechanic for Rocky Mountain Pre-Mix. He suffered increased knee pain while working in that job.

10. On May 19, 2009, Dr. Paz performed an independent medical examination for respondents. Claimant reported an onset of pain in his medial left knee while lining up a "three gear set" weighing between 45-50 pounds. Dr. Paz concluded that it was physiologically not probable that claimant injured his left MCL in the mechanism of injury reported by claimant. Dr. Paz explained in his deposition that collateral ligaments protect the knee from lateral forces. A medial collateral ligament strain occurs with "valgus deflection" of the knee joint. Dr. Paz testified that claimant's partial squatting position is not consistent with an MCL injury because the stress from that position would be across the quadriceps muscle and not the MCL. Dr. Paz found no evidence of valgus deflection in claimant's description and demonstration of his alleged injury that could have caused an MCL injury.

11. Claimant has proven by a preponderance of the evidence that he suffered an accidental injury to his left knee arising out of and in the course of his employment on November 21, 2008. Claimant's testimony is credible that he bent his left knee while holding a front axle gear to try to fit the gear onto the axle. He suffered medial left knee pain. Mr. Yauger and Mr. Schade admit that claimant was limping, although they contend that he did not report a work injury until after he was terminated on December 16, 2008. Claimant's history to Dr. Brassfield, Dr. Schwender, and Dr. Paz is reasonably consistent. Dr. Paz is not persuasive that the "mechanism" of injury is not consistent with an MCL strain. Dr. Paz ignored the fact that claimant was holding the gear assembly between his legs while bending at the knee and trying to fit the gear onto the axle. That mechanism is far more likely to exert lateral force to the knee.

12. Claimant has failed to prove by a preponderance of the evidence that he was unable to return to his regular occupation as a mechanic as a result of the work injury. Claimant continued to perform his regular duties up to December 16. Dr. Schwender released claimant to return to full duty without restrictions. Claimant admitted that he could have continued work after a mechanic after December 16, 2008.

CONCLUSIONS OF LAW

1. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Claimant

must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). As found, claimant has proven by a preponderance of the evidence that he suffered an accidental injury to his left knee arising out of and in the course of his employment on November 21, 2008.

2. To obtain TTD benefits, claimant must establish a causal connection between a work-related injury and a subsequent wage loss. §8-42-103(1)(a), C.R.S. To demonstrate entitlement to TTD benefits a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The term "disability," connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). A claimant suffers from an impairment of earning capacity when he has a complete inability to work or has restrictions that impair his ability to effectively and properly perform his regular employment such that he has a wage loss. *Ortiz v. Charles J. Murphy & Co.,* 964 P.2d 595 (Colo.App. 1998). As found, claimant has failed to prove by a preponderance of the evidence that he was unable to return to his regular occupation as a mechanic as a result of the work injury.

3. Respondents additionally assert that Claimant is precluded from receiving TTD benefits because he was responsible for his termination from employment pursuant to §8-42-105(4) C.R.S and §8-42-103(1)(g) C.R.S. (collectively "termination statutes"). Because claimant has failed to prove entitlement to TTD benefits, the affirmative defense that claimant was responsible for his termination of employment is moot.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers, including Dr. Schwender and his referrals.

2. Claimant's claim for TTD benefits from December 16, 2008 through March 31, 2009, is denied and dismissed.

DATED: October 7, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-749-778

ISSUES

¬ Did respondents overcome by clear and convincing evidence Dr. Hattem's 7% whole person rating for permanent medical impairment of the lumbar region of claimant's spine?

¬ Did claimant prove by a preponderance of the evidence that she is entitled to permanent partial disability benefits based upon impairment of her right upper extremity?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

1. Employer operates a meat packing business. Claimant's date of birth is March 16, 1960; her age at the time of hearing was 49 years. Claimant began working for employer on December 2, 2002. Claimant sustained an admitted injury while working for employer on August 8, 2007, when a side of beef hanging from the line dislodged from its hook and fell against claimant's right arm and right knee.

2. At the time of her injury, claimant was performing duties on the mark brisket line. Claimant's duties on the mark brisket line include hooking a side of beef with her left hand and then marking the beef, at the top, with her right hand. Claimant works from 6:45 a.m. until about 3:30 p.m. approximately 4 to 6 consecutive days a week. Claimant stands to perform her job duties, and she typically gets four breaks, including lunch.

3. Employer referred claimant to Hector Brignoni, M.D., who first treated her on August 9, 2007. Dr. Brignoni diagnosed pain on claimant's right shoulder, flank, hip, and knee, plus bruising and abdominal pain. Dr. Brignoni released claimant to return to modified duty work.

4. In addition to Dr. Brignoni, various other medical providers treated claimant, including: Gregory Denzel, D.O., who first evaluated claimant on August 14, 2007; Roberta Anderson-Oeser, M.D., who performed her initial evaluation of claimant on September 6, 2007; Scott Parker, D.C., who provided claimant chiropractic treatments, beginning on November 28, 2007; and Ron Carbaugh, Psy.D., who performed a pain psychology evaluation on December 17, 2007. Claimant also underwent numerous physical therapy treatments.

5. Gregory Denzel, D.O. noted that claimant complained of low back pain, right shoulder pain, and numbness in her right leg. Dr. Denzel remarked that claimant had slight decreased range of motion in her lumbar spine. Additionally, Dr. Denzel noted that

claimant's right shoulder had full active range of motion with minimal tenderness to her right shoulder. Dr. Denzel recommended physical therapy.

6. On September 6, 2007, Dr. Anderson-Oeser noted that claimant continued to complain of pain in her right shoulder, right elbow, lumbar area, and right knee despite the passage of pain. On examination, Dr. Oeser noted that claimant was in no acute distress and that claimant's right shoulder range of motion was within functional limits. Claimant's FABERE'S test was negative bilaterally. Dr. Oeser's impressions were right shoulder girdle strain, thoracic strain, lumbosacral strain, right shoulder impingement, and associated myofascial pain. Because of claimant's complaints of right lower extremity pain and paresthesia, Dr. Oeser ordered a magnetic resonance imaging (MRI) scan of the lumbosacral spine to rule out possible disc protrusion with impingement of the right S1 nerve root at the L5-S1 level.

7. Claimant underwent the MRI of her lumbar spine on September 7, 2007, which showed mild degenerative disk disease (DDD) from mid to lower lumbar spine and facet arthropathy (arthritis) at the L4-L5 and L5-S1 levels. The MRI also showed moderate left-sided foraminal narrowing at the L3-L4 level and mild to moderate left-sided foraminal narrowing at the L4-L5 level. There was no central stenosis of the spinal canal. However, the left L3 nerve root contacted the disk annulus just lateral to the neural foramen at the L3-L4 level. The MRI findings of the left-sided pathology at the L3 nerve root failed to correlate clinically with claimant's complaints of radiculopathy into her right lower extremity.

8. Dr. Oeser reevaluated claimant on October 4, 2007, when claimant reported pain at a level of 8/10. Claimant reported no long-term benefits even though she had attended eleven physical therapy sessions. Claimant stated that, while she felt good on the day of physical therapy treatments, her symptoms increased when she returned to work. Claimant stated she was unable to externally rotate her right shoulder due to the severity of her pain. Dr. Oeser reviewed claimant's lumbar spine MRI, and noted that the MRI did not show any evidence of right-sided nerve root impingement. On examination, Dr. Oeser noted that claimant walked with a normal tandem gait and was able to perform heel and toe walking. Claimant's right shoulder range of motion was restricted primarily with external and internal rotation. On examination of her lumbar spine, claimant had restricted range of motion in all planes. Dr. Oeser found the Fabere's testing positive on the right but negative on the left. Dr. Oeser noted the absence of objective pathology to attribute to claimant's complaints of symptoms radiating into her right lower extremity.

9. On October 8, 2007, Dr. Brignoni evaluated claimant and found decreased range of motion of her right shoulder due to complaints of 7/10 pain. Dr. Brignoni diagnosed claimant with right shoulder myofascial pain and possible tear of the rotator cuff. Dr. Brignoni referred claimant for an MRI of her right shoulder, which she underwent on October 18, 2007.

10. Dr. Brignoni reevaluated claimant on October 24, 2007, when claimant reported that she was either the same or worse than before. Dr. Brignoni noted that claimant's right shoulder MRI arthrogram showed that claimant had moderate to severe tendinosis in the rotator cuff but no rotator cuff tear. Dr. Brignoni diagnosed claimant with right shoulder tendinosis.

11. On November 21, 2007, Dr. Brignoni reevaluated claimant. Dr. Brignoni continued to note that claimant complained of low back pain with right-sided radiculopathy that was inconsistent with the lumbar MRI showing left-sided pathology at the L3 nerve root. Dr. Brignoni continued to find that claimant displayed a lot of pain behaviors. Dr. Brignoni initially recommended a psychological consultation on November 28, 2007, when claimant reported no improvement in her complaints despite significant therapeutic and diagnostic treatment.

12. Dr. Oeser followed up with claimant on November 29, 2007, when claimant reported pain at an 8/10 pain level. While claimant stated that she had ongoing pain in her right shoulder girdle, low back, and right lower extremity, Dr. Oeser was unsure why claimant had an increase in her symptoms. On examination, Dr. Oeser noted that claimant easily went from a seated to a standing position, ambulated around the examination room with a normal tandem gait, and performed heel and toe walking without difficulty. Dr. Oeser noted that it was unclear why claimant was having an increase in her symptoms and recommended a psychological consultation to evaluate claimant's pain symptoms.

13. Dr. Parker provided claimant with chiropractic treatment on November 28th, November 30th, December 5th, December 12th, and December 14, 2007. Claimant reported right-sided lower back pain, which she rated 8/10, abdominal pain, right elbow pain, and knee pain. Claimant failed to report any right shoulder pain to Dr. Parker. Throughout his various examinations of claimant, Dr. Parker found claimant displayed inconsistencies even though he found her lumbar range of motion was full in all planes on December 5, 2007 and December 14, 2007. At his November 28, 2007, examination of claimant, Dr. Parker found claimant's sacroiliac joint function on the right was not restricted. Dr. Parker found claimant's complaints of lower back pain and restricted motion inconsistent with his clinical observations of her in the examining room. Dr. Parker opined that claimant's prognosis was questionable due to her high pain complaints when compared to objective findings. Dr. Parker further opined that claimant had objective improvement of her low back pain despite her ongoing subjective pain complaints.

14. When Dr. Carbaugh performed a psychological evaluation of claimant on December 17, 2007, claimant complained of lower back pain, weakness and numbness in her legs, right knee pain, and right lower quadrant abdominal and groin pain. Claimant failed to mention any right shoulder pain or discomfort. Dr. Carbaugh noted that claimant's pain behavior was moderately high. Dr. Carbaugh determined that claimant has a somewhat passive-dependent personality style that was impacting her assumption of more responsibility for symptom management. Dr. Carbaugh diagnosed claimant with probable personality traits or coping style affecting pain management. Dr. Carbaugh provided claimant several counseling sessions to help her with pain management strategies. Dr. Carbaugh last counseled claimant on January 31, 2008. At that time, claimant reported that her subjective pain level had worsened, and she expressed concern about her ability to perform her job. Dr. Carbaugh continued to opine that claimant was taking a very passive approach to her symptom management.

15. Dr. Brignoni reevaluated claimant on January 14, 2008, and opined that claimant had pain magnification and pain behaviors despite undergoing physical therapy, chiropractic treatment, prescription medications, and lumbar spine injections. Dr. Brignoni

noted that, by her report, claimant's subjective complaints were not improving even though she continued to work within her restrictions.

16. On January 31, 2008, Dr. Oeser placed claimant at maximum medical improvement (MMI) for her right shoulder and lumbar spine injury. Dr. Oeser determined that claimant sustained no permanent medical impairment. Dr. Oeser also determined that claimant warranted no permanent physical activity restrictions as a result of her right shoulder and lumbar spine injury. Dr. Oeser noted that claimant's subjective complaints far outweighed objective findings on physical examination. Dr. Oeser found no physiological explanation for claimant's ongoing complaints of pain. On physical examination of claimant, Dr. Oeser continued to find that her right shoulder range of motion was within functional limits and that she had full passive range of motion of the shoulder. While claimant displayed restricted lumbar range of motion in all planes, her straight leg raising tests were negative bilaterally. Dr. Oeser opined that it was unclear as to what caused claimant's ongoing symptoms as claimant had minimal to no findings on examination or on claimant's imaging studies.

17. Dr. Brignoni reexamined claimant on February 11, 2008. Like Dr. Oeser, Dr. Brignoni noted the absence of any physiological explanation for claimant's ongoing complaints. Dr. Brignoni stated that, while claimant's pain drawings subjectively showed multiple areas of complaints, there was no physiological explanation tying those complaints to claimant's mechanism of injury. Dr. Brignoni agreed that claimant reached MMI, with no evidence of impairment. Dr. Brignoni nonetheless referred claimant for a functional capacity evaluation (FCE) to determine whether any physical activity restrictions might be warranted.

18. Dr. Brignoni last evaluated claimant on February 25, 2008, noting the FCE results were invalid due to claimant's magnified pain behavior. Dr. Brignoni noted that, while claimant had an extensive workup, she continued to complain that she was not improving. Dr. Brignoni again opined that there was no physiological explanation for claimant's ongoing symptoms. Dr. Brignoni placed claimant was at MMI, with no evidence of medical impairment and no permanent restrictions.

19. Claimant requested a Division Independent Medical Examination (DIME) through the Division of Workers' Compensation. The division appointed Albert Hattem, M.D., as the DIME physician. Dr. Hattem examined claimant on July 9, 2008 and September 24, 2008. Dr. Hattem agreed with Dr. Brignoni's determination that claimant reached MMI on February 25, 2008.

20. Dr. Hattem diagnosed claimant with Somatoform Disorder, noting:

> This case is very concerning because [claimant] has consistently complained of pain involving the entire right side of her body including her head. **Despite very extensive treatment** including pool-based therapy, land-based therapy, behavioral counseling, chiropractic manipulation, a right shoulder injection and 2 lumbar injections **her pain remains [unchanged]**. [Claimant] reports no improvement whatsoever since August 8, 2007. I agree with Dr. Oeser in that there is probably **a very significant psychosocial component to her pain complaints**. For this reason, I would be very hesitant to recommend any additional treatment directed at her physical complaints.

(Emphasis added). Dr. Hattem also diagnosed right shoulder impingement, mechanical low back pain, and myofascial pain complaints.

21. Dr. Hattem determined that claimant sustained permanent medical impairment of the right shoulder and the lumbar region of her lower back. Dr. Hattem rated claimant's right shoulder impairment at 14% of the upper extremity based upon abnormal motion of the shoulder. Dr. Hattem rated claimant's lumbar impairment at 7% of the whole person based upon a specific disorder of the spine under Table 53, II (C) of the *American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Revised)* (AMA Guides). Dr. Hattem determined that claimant had 6 months of documented pain with moderate to severe degenerative changes on structural tests. Dr. Hattem noted that claimant's MRI findings failed correspond to her complaints of right lower extremity symptoms. Dr. Hattem determined that claimant's demonstrated motion of her lumbar spine was unreliable and invalid for purposes of rating abnormal motion; he wrote:

> I elected not to assign an impairment for abnormal lumbar motion because [claimant's] **demonstrated motion is nonphysiologic**. When asked to actively move her lumbar spine she barely budged at all. This demonstrated motion is self-limited and does not correspond to MRI findings.

(Emphasis added).

22. Because he determined that claimant was demonstrating self-restricting range of motion of her lumbar spine and providing invalid measurements, Dr. Hattem performed repeat measurements of her range-of-motion testing on September 24th. Dr. Hattem reported:

> Lumbar range of motion measurements … today demonstrate self restricting behaviors as did her prior measurements on 7/9/08. Because this very restricted lumbar motion … does not correspond to objective findings, I once again recommend that they not be included in the impairment analysis.

Dr. Hattem's determination that claimant sustained impairment of 7% of the whole person based upon regional impairment of her lumbar spine is presumptively correct unless overcome by clear and convincing evidence. The Judge may not accord any special weight to Dr. Hattem's determination that claimant sustained impairment of 14% of her right upper extremity based upon abnormal shoulder motion.

23. At respondents's request, Robert W. Watson, Jr., M.D. performed an independent medical examination of claimant on January 22, 2009. Dr. Watson testified as an expert in the area of occupational medicine. Like Dr. Brignoni and Dr. Brignoni, Dr. Watson determined that claimant reached MMI on February 25, 2008, with no permanent impairment. Dr. Watson based his opinion upon the history he obtained from claimant, his examination findings, and his review of claimant's medical records. In his report and testimony, Dr. Watson persuasively explained the medical evidence supporting his opinions in this case. Dr. Watson's testimony was evidence-based, credible, and persuasive.

24. Based upon his clinical evaluation of claimant, Dr. Watson agreed with the opinions of Dr. Brignoni, Dr. Oester, and Dr. Hattem in finding that claimant's complaints and symptoms regarding her right shoulder and lumbar spine are nonphysiologic. Dr. Watson explained that nonphysiologic findings indicate that the examining physician is unable to substantiate a patient's subjective complaints of pain with objective, physiologic findings.

25. Dr. Watson offered the following examples of inconsistencies supporting his diagnosis of nonphysiologic findings: Claimant stated that she had a burning type of pain in her low back, pain in her right shoulder, and pain radiating from her right leg to her right arm. Dr. Watson noted that, while claimant walked very slowly and stiffly, she was able to step onto a step-stool to climb onto the examination table without any problem. On examination of her right shoulder, Dr. Watson noted that claimant had generalized tenderness with palpation and that claimant's range of motion was diminished to flexion and extension. Nonetheless, Dr. Watson observed that claimant was able to use her right arm for support when getting onto the examination table.

26. On examination of the lumbar spine, Dr. Watson noted that claimant had severely restricted lumbar range of motion. While claimant stated that she was unable to stand on her tiptoes, she could step up on the step-stool leading with the right foot to get onto the examination table. Dr. Watson noted that, while claimant had significant weakness on examination that would be inconsistent with her ability to walk, she nonetheless walked and used her right leg to get onto the examination table. Dr. Watson noted that, while claimant's lumbar range of motion was essentially non-existent on direct examination, claimant showed she was able to go from a lying to sitting position by turning and twisting her back.

27. Dr. Watson disagreed with Dr. Hattem's determination of permanent medical impairment. The Judge notes that Dr. Hattem, Dr. Watson, Dr. Oeser, and Dr. Brignoni all found that claimant had nonphysiologic findings. Additionally, both Dr. Oeser and Dr. Brignoni noted that claimant demonstrated significant pain behaviors and inconsistencies on evaluation. Dr. Watson persuasively questioned why he and Dr. Hattem found claimant displayed abnormal motion of the right shoulder when her treating physicians consistently found that claimant had full, functional range of motion of the shoulder at the time she reached MMI. Dr. Watson persuasively testified that, because her range of motion was within functional limits at MMI, claimant should have been able to use the shoulder normally. Dr. Watson noted that Dr. Hattem failed to comment or explain why his findings and recommendations were in such disagreement with the findings of the treating physicians at the time of MMI.

28. Dr. Watson diagnosed claimant with myofascial pain in the lumbar spine and right shoulder regions. Dr. Watson testified that myofascial pain involves pain in muscle tissue or the lining around the muscle. Dr. Watson opined that claimant complained of diffuse, nonphysiologic pain, which is non-localized pain throughout the body. Dr. Watson testified that, while claimant reported tenderness over her right shoulder and lower back, that tenderness was a subjective, rather than an objective finding. Dr. Watson persuasively testified that claimant did not have any ratable objective findings.

29. Crediting Dr. Watson's medical opinion, the findings of structural changes or pathology on the September 7, 2007, MRI of claimant's lumbar spine are very common in a person over 35 years of age. These structural changes are clinically insignificant in

claimant's case because claimant's objective pathology is left-sided, while claimant's acute injury actually occurred to the right side of her body. Dr. Watson persuasively testified that claimant's complaints involved her right side, which is inconsistent with the MRI findings of pathology on claimant's left side.

30. Dr. Watson persuasively testified that the invalid findings on the February 21, 2008, FCE further demonstrate that claimant is unreliable in reporting her symptoms and complaints. At the FCE, the therapist determined that claimant's subjective symptoms were less that reliable and that she complained of increased pain on axial loading testifying. Dr. Watson persuasively explained that a positive axial loading test meant that claimant's complaints were nonphysiologic. The FCE therapist also found that claimant had positive Waddell signs, which are used by examiners to assess whether an examination is consistent with physiologic abnormality. Dr. Watson noted that claimant had positive Waddell's signs indicating inconsistencies in her examination. The Judge has considered all evidence contrary to the opinions of Dr. Watson, Dr. Brignoni, and Dr. Oeser, regarding MMI, causation and impairment, and finds these opinions and evidence to be unpersuasive.

31. Respondents showed it highly probable that Dr. Hattem's 7% whole person rating for regional impairment of claimant's lumbar spine is incorrect. Dr. Hattem based this rating upon a diagnosis of a specific disorder according to Table 53, II (C) of the AMA Guides. Crediting Dr. Watson's medical opinion, the Judge finds: A specific disorder rating requires objective findings and a pathological diagnosis. Dr. Hattem's diagnosis of myofascial pain fails to represent a structural problem or pathology in the lumbar spine. Dr. Hattem's diagnosis of mechanical low back pain simply indicates that claimant complains of pain when moving her lower back, but that diagnosis fails to identify any specific structural lesion. Although Dr. Hattem used the diagnosis of mechanical low back pain to substantiate a specific disorder rating under Table 53, II (C), mechanical low back pain is not a ratable diagnosis absent a structural lesion to correlate with those complaints. Although claimant has structural changes shown on the MRI, the examining physician must correlate those degenerative changes with the physical examination and objective findings. Here, none of claimant's examining physicians found any correlation between claimant's complaints and structural changes on MRI. Even Dr. Hattem noted that claimant lacked any left-sided complaints that might otherwise correlate with left sided structural changes on the MRI. In addition, Dr. Hattem found claimant's report of symptoms unreliable. This finding was consistent with the findings of Dr. Watson, Dr. Brignoni, and Dr. Oester, who declined to assign claimant any permanent impairment because of nonphysiologic complaints. Even Dr. Hattem on 2 separate occasions was unable to obtain valid measurements of claimant's lumbar range of motion because she self-limited her motion. Based upon the totality of the evidence, the Judge finds it highly probable Dr. Hattem erred in providing claimant a 7% whole person rating under Table 53, II (C) of the AMA Guides.

32. Claimant failed to show it more probably true than not that her injury at employer resulted in permanent impairment of her right shoulder. Although Dr. Hattem gave claimant a 14% upper extremity rating for abnormal range of motion of the right shoulder, Dr. Hattem's finding of abnormal motion is inconsistent with the findings of Dr. Brignoni and Dr. Oester, who found that claimant had functional range of motion at the time of MMI. Although Dr. Watson found similar abnormal shoulder motion, Dr. Watson

opined that claimant's abnormal shoulder motion is unexplained when compared to the findings that claimant had functional range of motion at the time of MMI. Because the Judge finds claimant unreliable in reporting pain, symptoms, and limitations, there is no persuasive evidence showing it more probably true that her injury resulted in abnormal shoulder motion or that she sustained impairment of the right shoulder. Claimant thus failed to prove by a preponderance of credible evidence that she sustained impairment of her right upper extremity.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

A. Dr. Hattem's Rating:

Respondents argue that they overcame Dr. Hattem's 7% whole person by clear and convincing evidence. The Judge agrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Sections 8-42-107(8)(b)(III) and (c), *supra*, provide that the determination of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere differ-

ence of opinion between physicians fails to constitute error. *See, Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

A DIME physician must rate impairment in accordance with the provisions of the AMA Guides. Sections 8-42-101(3.7) and 8-42-107(8)(c), *supra*; *Wilson v. Indus. Claim Appeals Office,* 81 P.3d 1117 (Colo. App. 2003). The AMA Guides state that if an examiner's findings "are not consistent with those in the record, the step of determining the percentage of impairment is meaningless and should not be carried out until communication between the involved physicians or further clinical investigation resolves the disparity." *AMA Guides 3rd Edition Revised* § 2.1; *see Goffinett v. Cocat, Inc.,* W.C. No. 4-677-750 (I.C.A.O. April 16, 2008); *see also Vasquez v. Safeway, Inc.,* W.C. No. 4-497-976 (I.C.A.O. November 10, 2004). A DIME physician's deviation from the AMA Guides constitutes some evidence that the DIME physician's rating is incorrect." *Jaramillo v. Pillow Kingdom and Gen. Ins. Co. of Amer. d/b/a Safeco Ins.,* W.C. No. 4-457-028 (I.C.A.O. September 10, 2002).

Here, the Judge found that respondents showed it highly probable Dr. Hattem erred in providing claimant a 7% whole person rating under Table 53, II (C) of the AMA Guides based upon regional impairment of the lumbar spine. Respondents thus overcame Dr. Hattem's 7% whole person by clear and convincing evidence.

As found, Dr. Hattem based this rating upon a diagnosis of a specific disorder according to Table 53, II (C) of the AMA Guides. The Judge credited the medical opinion of Dr. Watson in finding: A specific disorder rating requires objective findings and a pathological diagnosis. Dr. Hattem's diagnosis of myofascial pain fails to represent a structural problem or pathology in the lumbar spine that might otherwise be ratable under Table 53, II (C). Dr. Hattem's diagnosis of mechanical low back pain simply indicates that claimant complains of pain when moving her lower back, but that diagnosis fails to identify any specific structural lesion. Although Dr. Hattem used the diagnosis of mechanical low back pain to substantiate a specific disorder rating under Table 53, II (C), mechanical low back pain is not a ratable diagnosis absent a structural lesion to correlate with those complaints. Although claimant has structural changes shown on the MRI, the examining physician must correlate those degenerative changes with the physical examination and objective findings. Here, none of claimant's examining physicians found any correlation between claimant's complaints and structural changes on MRI. Even Dr. Hattem noted that claimant lacked any left-sided complaints that might otherwise correlate with left sided structural changes on the MRI.

In addition, Dr. Hattem found claimant's report of symptoms unreliable. This finding was consistent with the findings of Dr. Watson, Dr. Brignoni, and Dr. Oester, who declined to assign claimant any permanent impairment because of nonphysiologic complaints. Even Dr. Hattem on 2 separate occasions was unable to obtain valid measurements of claimant's lumbar range of motion because she self-limited her motion, which further demonstrated that claimant's report of symptoms is unreliable. The Judge considered claimant's unreliable reporting and the totality of the evidence in finding it highly probable that Dr. Hattem's incorrectly provided claimant a 7% whole person rating.

The Judge concludes that claimant's claim for an award of permanent partial disability benefits based upon Dr. Hattem's 7% whole person rating should be denied and dismissed.

B. Upper Extremity Impairment:

Claimant argues she has proven by a preponderance of the evidence that she is entitled to permanent partial disability benefits based upon impairment of her right upper extremity. The Judge disagrees.

Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

Although the opinions and findings of the DIME physician may be relevant to a determination of permanent partial disability under the schedule of disabilities, a DIME physician's opinion is not mandated by the statute nor is the ALJ required to afford it any special weight. *See Delaney v. Industrial Claim Appeals Office*, 30 P.3d 691 (Colo. App. 2000) It is only after the ALJ determines the claimant sustained impairment and that the impairment is whole person impairment that the DIME physician's rating becomes entitled to presumptive effect under §8-42-107(8)(c), *supra*. *See Egan v. Industrial Claim Appeals Office*, 971 P.2d 664 (Colo. App. 1998). (DIME provisions do not apply to the rating of scheduled injuries).

The Judge found that claimant failed to show it more probably true than not that her injury at employer resulted in permanent impairment of her right shoulder. Claimant thus failed to prove by a preponderance of the evidence that she is entitled to permanent partial disability benefits based upon impairment of her right upper extremity.

Although Dr. Hattem gave claimant a 14% upper extremity rating for abnormal range of motion of the right shoulder, the Judge found that Dr. Hattem's finding of abnormal motion was inconsistent with the findings of Dr. Brignoni and Dr. Oester at the time of MMI. Dr. Brignoni and Dr. Oester found that claimant had functional range of motion at the time of MMI. Although Dr. Watson and Dr. Hattem found similar abnormal shoulder motion, the Judge credited the persuasive testimony of Dr. Watson, who opined that claimant's abnormal shoulder motion is unexplained when compared to the findings that claimant had functional range of motion at the time of MMI. Because the Judge found claimant unreliable in reporting pain, symptoms, and limitations, there is no persuasive evidence showing it more probably true that her injury resulted in abnormal shoulder motion or that she sustained impairment of the right shoulder.

The Judge concludes that claimant's claim for an award of permanent partial disability benefits based upon impairment of the right shoulder should be denied and dismissed.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's claim for an award of permanent partial disability benefits based upon Dr. Hattem's 7% whole person rating is denied and dismissed.

2. Claimant's claim for an award of permanent partial disability benefits based upon impairment of the right shoulder is denied and dismissed.

3. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _October 7, 2009_

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-729-187

ISSUES

- Whether Claimant's impairment resides on the schedule or whether Claimant has sustained impairment as to the whole person.
- Whether the Division Independent Medical Examination physician's opinions are entitled to presumptive effect with respect to the impairment rating
- Whether Claimant is entitled to additional compensation for a cosmetic deformity resulting in functional impairment.

FINDINGS OF FACT

1. On July 10, 2007, Claimant sustained an admitted injury to his right eye for which he received medical treatment that included surgery.
2. Claimant's authorized treating physician, Ronald Wise, M.D., placed Claimant at maximum medical improvement (MMI) on December 18, 2008. In his report, Dr. Wise noted that Claimant continues to complain of profound vision loss, but that such loss has a significant nonorganic component.
3. Dr. Wise rated Claimant's visual system impairment by using the Guides to the Evaluation of Permanent Impairment (Guides) and concluded as follows: "A total eye loss using the combined value charts on page 256 revealed a 61% rating. This rating was calculated using the 53% rating for visual acuity, 12% rating for visual fields, and 5% rating for ocular disturbances rated by the papillary and corneal abnormalities. A total visual system impairment rating using table 5 page 169 revealed a 15% rating. This translates to a total whole person impairment rating of 14% using table 6, page 172."

4. Respondents filed a Final Admission of Liability (FAL) on January 15, 2009, that admitted for a scheduled impairment of 61% part of Body Code 33, which translates to "Blindness One Eye."

5. Claimant objected to the FAL and underwent a Division Independent Medical Examination (DIME) with W. Bruce Wilson, M.D. Dr. Wilson issued a report dated March 12, 2009, wherein he estimated Claimant's vision at 20/50 based on Claimant's subjective reports. Dr. Wilson, however, did not feel that Claimant's vision was as bad as he claimed and noted a number of inconsistencies between Claimant's subjective reports and the objective findings.

6. Dr. Wilson analyzed Claimant's impairment using the Guides. First, Dr. Wilson assumed that Claimant had only hand motion vision on the right. Such assumption led to the following conclusions: Under Table 2, page 163, 99% impairment; no abnormality in the visual fields, which he felt was not highly possible; Under Table 5, page 169, 25% loss; Under the combined values chart on page 254, a 26% loss; and under Table 6, page 172, 25% whole person impairment.

7. Dr. Wilson then assumed that Claimant had vision of 20/40 in perspective and concluded as follows: 57% under Table 6, page 163; 0% for visual fields; 14% for visual acuity; a combined value of 15%; and a whole person impairment of 14%. Dr. Wilson estimated that Claimant does not have total vision loss in his right eye and has 14% whole person impairment.

8. On May 18, 2009, Respondents filed another FAL that admitted for a scheduled impairment of 57% due to blindness in one eye.

9. Claimant's right eye has some redness and there is a white spot on the right side of his iris.

10. Claimant has not suffered total loss of his right eye nor has he suffered total loss of use of his right eye. Claimant is not totally blind in his right eye pursuant to the medical records offered into evidence. Although Claimant has provided subjective reports of profound vision loss, both Drs. Wise and Wilson felt that Claimant's subjective reports do not correlate with the objective findings.

11. No physician has provided an impairment rating pursuant to Section 8.6 of the Guides for cosmetic deformities that do not otherwise alter ocular function. No physician has determined that any cosmetic deformity of Claimant's eye affects the functioning of his face.

CONCLUSIONS OF LAW

1. Section 8-42-107, C.R.S., sets forth two different methods of compensating medical impairment. Subsection (2) provides a schedule of disabilities and Subsection (8) provides for whole person ratings and the DIME process for resolving disputes about such whole person ratings. Whether a claimant sustained a scheduled or nonscheduled injury is a question of fact for the ALJ. *Strauch v. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo. App. 1996). Although the opinions and findings of the DIME physician may be relevant to this determination, a DIME physician's opinion is not mandated by the statute nor is the ALJ required to afford it any special weight. *See Delaney v. Industrial Claim Appeals Office,* 30 P.3d 691 (Colo. App. 2000); and *Webb v. Circuit City Stores, Inc.*, W.C. No. 4-467-005 (ICAO, August 16, 2002).

2. The schedule of specific injuries includes in § 8-42-107(2)(gg), C.R.S., total blindness of one eye or some percentage thereof. As pertinent here, under § 8-42-107(8)(c.5), C.R.S., when an injury results in total loss or total loss of use an eye, the benefits for such loss shall be determined as non-scheduled injuries. Because Claimant has not sustained a total loss of use or a total loss of his right eye, § 8-42-107(8)(c.5), C.R.S., does not apply to his injury. Accordingly, Claimant's medical impairment resides on the schedule and Claimant has sustained some percentage of total blindness in one eye.

3. Because the DIME opinion regarding the scheduled impairment rating is not given presumptive effect, the Judge must determine the appropriate scheduled rating based upon a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

4. The opinions of Dr. Wise are more persuasive than those of Dr. Wilson. Dr. Wilson provided two different impairment ratings each of which depended on different determinations of Claimant's actual vision loss. Thus Dr. Wilson's opinions appear speculative as to Claimant's actual vision loss and the appropriate impairment rating. Dr. Wise, however, provided a more definitive opinion concerning Claimant's impairment. Based on the persuasive opinions of Dr. Wise, the Judge concludes that Claimant has sustained 61% total blindness in one eye pursuant and is entitled to permanent disability benefits pursuant to § 8-42-107(2)(gg), C.R.S.

5. Alternatively, Claimant contends that he has sustained a cosmetic deformity, which is a non-scheduled injury, that would entitle him to additional compensation pursuant to the opinions set forth in *Gonzales v. Advanced Component Systems*, 949 P.2d 569 (Colo. 1997). Claimant has not established entitlement to such additional benefits. None of the medical records establish that Claimant has sustained a cosmetic deformity to his eye or face that would impair Claimant's function. In addition, the Judge observed Claimant's eye and face during the hearing and found that Claimant had some redness in his eye and a small white spot on the right side of his iris. These abnormalities do not rise to the level of a cosmetic deformity that would result in a functional impairment.

ORDER

It is therefore ordered that:

1. Claimant has sustained 61% total blindness in one eye pursuant and is entitled to permanent disability benefits pursuant to § 8-42-107(2)(gg), C.R.S.,

2. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

3. All matters not determined herein are reserved for future determination.

DATED: October 7, 2009

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-499-071

ISSUES

The following issues were raised for consideration at hearing:

1. Whether Claimant's Petition to Reopen based on a worsened condition should be granted;
2. Whether Claimant is entitled to medical benefits, including treatment for narcotic drug addition;
3. If the Petition to Reopen is granted, whether Claimant is entitled to temporary disability benefits from the date of reopening and continuing; and
4. Whether Respondents are entitled to offsets.

FINDINGS OF FACT

Having considered the evidence presented at hearing, the following Findings of Fact are entered.

1. Claimant was born on June 17, 1980. When she was twenty years old, on April 6, 2001, Claimant suffered a compensable injury to her right upper extremity. That injury was subsequently diagnosed as right ulnar neuropathy and Complex Regional Pain Syndrome (CRPS). Claimant was treated by numerous physicians, underwent surgical procedures including implantation of a spinal cord stimulator, and, on August 26, 2005, Claimant was declared by her then treating physician, Dr. Nelson, to be at maximum medical improvement (MMI).

2. Claimant received a 13% whole person impairment rating, and Respondents initially filed a final admission consistent with said rating on December 9, 2005. Amended or corrected final admissions were subsequently filed to properly state the amount of permanent partial disability benefits, the last of which is dated April 24, 2006. There was no objection to the final admission, and PPD benefits totaling $52,655.15 were paid to Claimant per the admission. Respondents also admitted for maintenance medical benefits that were reasonably necessary and related to the injury.

3. On November 9, 2006, Claimant petitioned to reopen her claim based on a letter report from Dr. John Tyler, dated October 16, 2006. Until the current proceeding that commenced on February 3, 2009, Claimant's Petition to Reopen filed in 2006 had not been litigated or adjudicated. The November 9, 2006, Petition to Reopen was filed by attorney James May. No application for hearing was filed. Subsequently, Claimant's representation in this matter was assumed by Steven Mullen, Esq. and a second Petition to Reopen was filed on September 5, 2008. Attorney Mullens appeared in this matter arguing that the November 9, 2006, Petition to Reopen was timely filed and should be adjudicated in this matter. The ALJ finds that the November 9, 2006, Petition to Re-

open was timely filed and remains available for determination and is decided by this order.

4. Subsequent to this matter being closed by Final Admission of Liability, Claimant underwent a series of surgeries for this compensable injury and in connection with those surgical interventions and additional treatment, Claimant has been prescribed analgesic narcotic pain medication to relieve the pain that Claimant has experienced as a direct result of her work injury, her CRPS, and various treatments for her work injury, including, but not limited to, multiple surgical procedures.

5. Claimant established by preponderance of the evidence that subsequent to the Final Admission of Liability that was filed in this matter, Claimant's condition worsened necessitating active treatment including implantation and removal, as well as reimplantation, of nerve stimulators.

6. It is found that as a direct result of the narcotic medication prescribed for Claimant, Claimant developed a narcotic dependency and subsequently a narcotic addiction that has worsened over time and for which addiction Claimant now requires and should be awarded medical treatment in this compensable workers' compensation claim.

7. Dr. John Tyler testified at hearing. He also authored a letter dated October 16, 2006, that accompanied Claimant's Petition to Reopen. Dr. Tyler's opinions in this matter are found to be persuasive, credible, and more reliable than the opinions offered by Dr. John Sacha, Respondents' forensic witness.

8. Dr. Tyler's assessment of Claimant's work related injury, pain resulting from the injury, Claimant's need for medication to relieve the pain from the injury, as well as Claimant's progressively worsened addiction and drug seeking secondary to the addiction are likewise found to be credible and persuasive. Dr. Tyler has strongly recommended that Claimant be provided with addiction treatment commencing with a thirty day, or longer, inpatient program. The ALJ finds that Dr. Tyler's recommendation for that treatment is reasonable and that Respondents are ordered to provide that treatment for Claimant.

9. On February 3, 2009, Claimant testified in direct testimony and established a *prima facie* entitlement to reopening her claim. On cross-examination Respondents' counsel inquired of numerous instances in which Claimant engaged in drug seeking behavior as Claimant's addiction developed and worsened. Respondents counsel's questions were met with Claimant's denials and her allegations that the records were incorrect insofar as the records suggested that Claimant did in fact engage in repeated serious and numerous successful efforts to obtain and improperly use narcotic medication as a result of her addiction.

10. When hearing commenced on June 15, 2009, Claimant testified in redirect testimony that her prior testimony on cross-examination given on February 3, 2009, was

untruthful. Claimant admitted that she had engaged in all of the conduct inquired about by Respondents' counsel. Claimant further testified that she acknowledged that she has a serious drug addiction that required treatment. When asked why she gave untruthful testimony about her prior conduct during the hearing that was held on February 3, 2009, Claimant testified on June 15, 2009, that she was embarrassed about and humiliated by the factual history concerning her drug seeking behavior and addiction and she disliked Respondents' counsel and elected to argue with him.

11. The ALJ does not condone Claimant's false testimony on cross-examination. The ALJ's job is to assess the credibility of witnesses. The ALJ concludes that based on the totality of Claimant's testimony as well as the testimony of Dr. Tyler, that Claimant is persuasive and credible with regard to the material issues of fact to be decided in this proceeding.

12. Respondents argue that Claimant's untruthful testimony on cross-examination, in combination with instances prior to her injury which Respondents allege evidence a predisposition to drug addiction, should cause the ALJ to conclude that Claimant will not be responsive to drug treatment and does not deserve the treatment because her condition is not work related. However, the ALJ does not reach that conclusion. The ALJ finds that Claimant's pre-work injury activities do not allow the ALJ to conclude that Claimant was a drug addict before the work injury. And, Claimant's denial of her drug seeking activities on cross-examination does not lend support for the conclusion that Claimant is not a candidate for drug treatment or that her testimony should be regarded as not credible.

13. For a period of approximately one year prior to the commencement of hearing in this matter, Claimant has attended outpatient treatment for drug addiction/ chemical dependency and successfully completed that program. During the course of the program, she tested positive for cocaine one time, but otherwise, benefited from the program, and as noted above, successfully completed that treatment.

14. Claimant testified on June 15, 2009, that she fully understands that she is not finished with treatment for her drug addiction. She thinks about using constantly and knows that she has to undergo additional treatment prior to reaching MMI in connection with her narcotic addiction.

15. Respondents offered the testimony of Dr. John Sacha, MD, at the proceedings that were held on June 15, 2009, in defense of Claimant's Petition to Reopen. Dr. Sacha testified that he has expertise with regard to issues of medical legal causation and that he teaches the Level II program for the Division of Workers' Compensation on the topic of medical causation in workers' compensation claims. Dr. Sacha testified that Claimant's drug addiction is not related to her work injury or the treatment that Claimant received for her injury because, according to Dr. Sacha, Claimant's personality and early childhood demonstrate that Claimant was predisposed to becoming a drug addict. Based on that predisposition, Dr. Sacha opined that, there was no causal relationship established between Claimant's injury and her treatment for the injury, including pre-

scription narcotics that increased in quantity and strength in an effort to address the pain that Claimant experienced as a result of Claimant's work injury.

16. It is found that Dr. Sacha is less credible than Dr. Tyler. It is further found that Dr. Sacha analysis of Claimant's medical records pertaining to Claimant's childhood and young adulthood alleged use of alcohol, marijuana, and cocaine was not persuasive.

17. Dr. Tyler was called on rebuttal and expressed the opinion that Dr. Sacha's denial of treatment recommendations for Claimant is professionally unacceptable. Dr. Tyler's testimony is reasonable and persuasive. Dr. Tyler reiterated his opinion that Claimant is not at MMI, consistent with his letter of October 16, 2006. Dr. Tyler credibly opined that Claimant developed a significant drug addiction, secondary to prescription medications that Claimant was provided to treat her work injury and that Claimant requires additional drug addiction treatment starting with an inpatient treatment program of at least thirty days duration. The ALJ finds Dr. Tyler's recommendations and conclusions to be persuasive.

18. Claimant has continued to treat for her work injuries subsequent to the Final Admission of Liability that was filed in 2005. Respondents have provided Claimant with continued maintenance medical care for her work injury. The ALJ finds and concludes that medical care must include treatment for Claimant's work injury treatment related drug addiction.

19. As a result of the inpatient treatment program that Respondents are liable to provide Claimant, Claimant is disabled from her usual employment and is therefore entitled to TTD. On November 9, 2006, Claimant petitioned to reopen claim based on a letter/ report from Dr. John Tyler dated October 16, 2006. Claimant filed a second petition to reopen claim on September 5, 2008, incorporating the earlier petition and claiming that the matter should be reopened because of change in medical condition, error and mistake. At the initial hearing on Claimant's Petition to Reopen on February 3, 2009, the Court ruled that the Petition to Reopen to be considered is the November 9, 2006 Petition based on the Claimant's worsened condition.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the ALJ enters the following Conclusions of Law.

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of providing entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after con-

sidering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

4. The ALJ determined at the February 3, 2009, hearing in this matter that this matter would proceed to hearing on the Claimant's November 9, 2006, Petition to Reopen based on a worsened condition. It is found that the November 9, 2006, Petition tolled the statute of limitation provided for under Section 8-43-303(1), C.R.S. The ALJ relies upon the *Mascitelli v. Giuliano & Sons Coal Co*., 157 Colo. 240, 402 P.2d 192 (1965), to find that Claimant's petition to reopen was not time barred and that the six-year period to reopen a claim is tolled on the date claimant files a petition to reopen. It is further found and concluded that Claimant's filing of the application for hearing outside the six-year period provided by Section 8-43-303 does not require a determination that Claimant is precluded from meeting the statutory deadline. *Federal Express v. Industrial Claims Appeals Office*, 51 P.3d 1107 (2002).

5. Claimant contends that she is entitled to TTD from the date of the Petition to Reopen and therefore an order should be entered finding that TTD commences from November 9, 2006 and continues until terminated by law. Claimant contention is premised on her assertion that she is not at MMI and requires additional treatment for the work injury.

6. It is found and concluded that Claimant is entitled to TTD commencing November 9, 2006 and continuing until terminated by law. Respondents are entitled to offset permanent partial disability payments totaling $52,655.15 against TTD owed to Claimant.

7. Furthermore, the respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Accordingly, it is concluded that Claimant requires continued medical treatment, including an inpatient drug treatment program of at least 30 days in length in order to treat her narcotic drug addiction.

ORDER

It is therefore ordered that:

1. Claimant's November 9, 2006, Petition to Reopen is granted.

2. Respondents shall be liable to Claimant for TTD commencing November 9, 2006, and continuing until terminated by law.

3. Respondents are entitled to offset permanent partial disability payments totaling $52,655.15 against TTD owed to Claimant.

4. Respondents shall be liable for medical benefits to cure and relieve Claimant of the effects of the April 6, 2001, work injury. The medical benefits shall include an inpatient drug treatment program of at least 30 days in length.

5. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

6. Respondents shall be entitled to all appropriate offsets provided by law.

All matters not determined herein are reserved for future determination.

DATED: October 7, 2009

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-731-996

ISSUES

The issues determined herein are temporary total disability ("TTD") benefits, specifically whether claimant's entitlement to those benefits ended because she was at maximum medical improvement ("MMI"). The parties stipulated that the employer is entitled to an offset for long-term disability benefits pursuant to statute.

FINDINGS OF FACT

1. Claimant began work as an x-ray technician for the employer in May 1999. She suffered previous right shoulder injury and underwent decompression surgery on December 19, 2006. She then returned to regular duty work.

2. On March 23, 2007, claimant suffered an admitted right upper extremity injury when a patient in a wheelchair pulled on claimant's right arm.

3. On March 23, 2007, Dr. Lund examined claimant, who reported a history of suffering temporary numbness in her right arm after the injury. Dr. Lund prescribed physical therapy, which did not greatly improve claimant's condition.

4. On August 9, 2007, Dr. Lund examined claimant and noted a report of right trapezius pain. On August 21, 2007, Dr. Weinstein performed surgery on the right shoulder for a subacromial decompression, distal clavicle resection, and debridement of a partial rotator cuff tear.

5. On September 21, 2007, claimant reported to Dr. Lund that she suffered increasing pain in her right shoulder, radiating down her right arm. Claimant underwent additional physical therapy, which included treatment of her neck and scapula.

6. On February 20, 2008, Dr. Pak performed surgery for a right shoulder labral tear.

7. Claimant continued to complain of right upper extremity numbness and radiating pain.

8. On July 7, 2008, Dr. Castrejon determined that claimant was at MMI.

9. On August 13, 2008, respondents filed a final admission of liability for a scheduled impairment rating and for post-MMI medical benefits. Claimant objected and requested a Division Independent Medical Examination ("DIME").

10. On December 2, 2008, Dr. Timothy Hall performed the DIME. Dr. Hall diagnosed rotator cuff and labral tears, probable brachioplexus stretch injury, myofascial pain and spasm in the cervicothoracic spine with headaches, and postural distortions. Dr. Hall agreed that claimant was at MMI for her shoulder problem, but he determined that claimant had a cervical spine injury that was related to her admitted industrial injury and subsequent treatment. Dr. Hall concluded that claimant probably had not suffered an initial injury to the cervical spine, but the postural distortions created by failed treatments led to the cervical spine dysfunction. Dr. Hall determined that claimant was not at MMI for this cervical spine condition. He recommended an electromyography ("EMG") of the right upper extremity and a magnetic resonance image ("MRI") of the neck. If those tests were negative, he recommended physical therapy on the cervicothoracic spine.

11. On February 2, 2009, Dr. Christopher Ryan performed an independent medical examination ("IME") for claimant. Dr. Ryan agreed with Dr. Hall that claimant was not at MMI and needed an EMG, MRI, and physical therapy for her cervical spine condition, which was related to her admitted work injury.

12. On March 9, 2009, Dr. Brian Beatty performed an IME for respondents. Dr. Beatty concluded that claimant was at MMI on July 2, 2008. He found decreased range of motion in all planes of the cervical spine, which he found to be unexpected with a subsequent cervical spine soft tissue problem. He found glove-like sensory loss and decreased grip strength that was not related to a shoulder injury. Dr. Beatty disagreed with Dr. Hall that claimant had a probable brachial plexus injury. He diagnosed the rotator cuff tear, labral tear, and possible adhesive capsulitis.

13. Drs. Hall, Ryan, and Beatty testified at hearing consistent with their reports. Dr. Beatty reiterated his opinion that the mechanism of injury was inconsistent with a brachial plexus stretch injury. Dr. Ryan noted that the mechanism of injury was consistent with an injury to the upper portion of the brachial plexus. Dr. Ryan also noted that the shoulder joint complex involved the interrelationship of many muscles and that claimant's cervical spine pain was likely due to compensation due to the shoulder injury.

14. Respondents have failed to prove by clear and convincing evidence that the determination by the DIME, Dr. Hall, is incorrect. Dr. Hall determined that claimant was not at MMI for the March 23, 2007, work injury because she needed an EMG, repeat MRI of the neck, and then soft tissue treatment for the neck. Dr. Ryan's opinion testimony supported the determination by the DIME. Dr. Beatty disagrees, but his disagreement does not demonstrate that it is highly probable that Dr. Hall is incorrect. Dr. Hall and Dr. Ryan are persuasive that the right shoulder injury and subsequent treatment probably led to cervical spine symptoms and reduced range of motion.

CONCLUSIONS OF LAW

1. Claimant was unable to return to the usual job due to the effects of the work injury. Consequently, claimant is "disabled" within the meaning of section 8-42-105, C.R.S. and is entitled to TTD benefits. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999); *Hendricks v. Keebler Company*, W.C. No. 4-373-392 (Industrial Claim Appeals Office, June 11, 1999). Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused claimant to leave work, and claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Respondents agreed at hearing that the only defense to TTD benefits was that claimant reached MMI.

2. Section 8-42-107(8)(b)(III), C.R.S., provides that the determination of the DIME with regard to MMI shall only be overcome by clear and convincing evidence. The determination of DIME concerning the cause of claimant's impairment is binding unless

overcome by clear and convincing evidence. *See Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Cudo v. Blue Mountain Energy Inc.*, W.C. No. 4-375-278 (Industrial Claim Appeals Office, October 29, 1999). A fact or proposition has been proved by "clear and convincing evidence" if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). In this case, the DIME, Dr. Hall, determined that claimant was not at MMI. Consequently, respondents must prove by clear and convincing evidence that this determination is incorrect.

3. "Maximum medical improvement" is defined in Section 8-40-201(11.5), C.R.S. as:

> A point in time when any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition. The requirement for future medical maintenance which will not significantly improve the condition or the possibility of improvement or deterioration resulting from the passage of time shall not affect a finding of maximum medical improvement. The possibility of improvement or deterioration resulting from the passage of time alone shall not affect a finding of maximum medical improvement.

Reasonable and necessary treatment and diagnostic procedures are a prerequisite to MMI. MMI is largely a medical determination heavily dependent on the opinions of medical experts. *Villela v. Excel Corporation*, W.C. Nos. 4-400-281, 4-410-547, 4-410-548, & 4-410-551 (Industrial Claim Appeals Office, February 1, 2001). As found, respondents have failed to prove by clear and convincing evidence that the determination by the DIME, Dr. Hall, is incorrect. Consequently, claimant is entitled to TTD benefits commencing July 2, 2008, and continuing thereafter until modified or terminated according to law. Because claimant is not at MMI, the issue of permanent partial disability benefits is not ripe for determination.

ORDER

It is therefore ordered that:

1. The employer shall pay to claimant TTD benefits at the admitted rate commencing July 2, 2008, and continuing thereafter until modified or terminated according to law. The employer is entitled to an offset for long-term disability benefits pursuant to statute.

2. The employer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

3. All matters not determined herein are reserved for future determination.

DATED: October 8, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-769-486

ISSUES

The issues determined herein are termination of temporary total disability ("TTD") benefits and reduction of benefits pursuant to section 8-42-112(1)(d), C.R.S.

FINDINGS OF FACT

1. Claimant has been employed as an "unloader" by the Employer from November 27, 2007.

2. Claimant suffered an admitted industrial injury to his low back on August 24, 2008.

3. Claimant suffered a previous low back injury in 1991. He underwent surgery.

4. In 1997, claimant suffered another low back injury. He underwent repeat surgery, but the record evidence did not demonstrate that claimant had any work restrictions as of November 27, 2007. After his 1997 injury and surgery, claimant returned to work in cabinetry and woodworking, lifting over 50 pounds. He continued to suffer some periodic low back pain. On June 22, 2005, he underwent a magnetic resonance image ("MRI") of the lumbar spine.

5. On November 27, 2007, the employer offered claimant the job of unloader. The employer presented claimant with a list of essential job function. Claimant signed an acknowledgment that he could perform the job duties of an unloader either with or without reasonable accommodations. Claimant requested no reasonable accommodations. The Employer did not ask about any prior health problems and claimant did not discuss any such problems.

6. Claimant performed the job duties of an "unloader" from November 27, 2007, through August 23, 2008, without any reported difficulty.

7. Dr. Sacha testified by deposition that Claimant should have had a 20-pound lifting restriction due to his original back surgery. The medical records from the

previous injuries do not demonstrate that claimant had any such lifting restriction in effect on November 27, 2007.

8. Since the industrial injury, the Claimant has been primarily treated by providers at Concentra Medical Centers, and also has been seen by Dr. Shockney, a psychologist, Dr. Mitchell, an orthopedic surgeon, and Dr. Bissell.

9. On August 28, 2008, Dr. Wallace excused claimant from work due to his work injury.

10. On September 8, 2008, Dr. Shaut restricted claimant from lifting and required him to change positions frequently.

11. On September 12, 2008, the insurer filed a general admission of liability for TTD benefits commencing August 28, 2008, and continuing.

12. On September 22, 2008, Dr. Gray restricted claimant from lifting, carrying, pushing, or pulling over five pounds, as well as from squatting, kneeling, or crawling. Dr. Gray continued these restrictions on October 14 and 16.

13. On September 29, 2008, Dr. Sacha also began to provide treatment for claimant.

14. On October 20, 2008, Dr. Sacha determined that claimant was at maximum medical improvement ("MMI"). He continued the same restrictions already imposed by Dr. Gray.

15. On October 22, 2008, Nurse Practitioner Kletter examined claimant and released claimant to work with the following restrictions: lifting, carrying, pushing, and pulling to five pounds, no squatting, kneeling, or prolonged standing or walking.

16. On October 23, 2008, N.P. Kletter signed a Summary of Limitations form that was also signed by an unidentified person. The form indicated that, effective October 22, claimant was able to perform the jobs of UPC Clerk, Invoice Clerk, Markdown Clerk, Fitting Room Attendant, Operator, Greeter, Film Clerk, and Safety Monitor

17. The Employer prepared an offer of modified employment for Claimant as a greeter. The offer was open from October 29 until 4:00 p.m. on November 8, 2008.

18. On October 23, 2008, claimant met with representatives of the employer who attempted to hand the written offer of modified employment to claimant, but claimant refused to receive a copy directly from the Employer. Claimant told the employer to mail the offer by certified mail.

19. On October 23, 2008, the Employer sent the offer to claimant by Certified Mail, which was returned unclaimed to the Employer. The employer erroneously ad-

dressed the envelop to an incorrect zip code, but the error was corrected on the envelope. Parol evidence established that claimant received three Post Office notifications On October 25, November 1, and November 10, 2008, that he had certified mail awaiting him.

20. On November 3, 2008, claimant was contacted by telephone by an employer representative, Mr. Imperiale. Claimant agreed to go to the employer's office on November 4, 2008, to sign the written offer of modified employment. Claimant did not go to the office to sign the offer. Claimant and Mr. Imperiale agreed that claimant would go to the office on November 6 to sign the offer. Claimant again did not go to the office.

21. Claimant never picked up the certified mail at the Post Office. The letter was returned to the employer. Claimant did not have actual knowledge of the written offer of modified employment.

22. On November 10, 2008, Dr. Sacha determined that claimant had no permanent impairment from the work injury. Dr. Sacha imposed restrictions against more than 20 pounds of material handling and performing only occasional bending and twisting.

23. On approximately November 20, 2008, an employer representative called claimant and asked when he would be able to return to work. Claimant replied that his condition was worse.

24. On November 25, 2008, Ms. Anslow, the Human Resource Manager for the employer, wrote to claimant asking him to respond as soon as possible if he intended to return to work for the employer. The thrust of the letter was to inform claimant that his Family Medical Leave ("FML") had expired and that his extended leave of absence until December 4, 2008, did not prevent the Employer from replacing him. The return address on the employer's letter was to the office in Arkansas, although Ms. Anslow worked in Colorado Springs.

25. On December 6, 2008, claimant sent a reply to Ms. Anslow's letter correctly addressed to the return address on the November 25, 2008 letter, but the reply did not arrive to Ms. Anslow until January 21, 2009. Claimant stated that he intended to return to work.

26. On December 4, 2008, the employer, through Ms. Anslow, terminated claimant's employment due to the fact that he did not return to work when his leave of absence expired.

27. Claimant continued to receive medical treatment, including epidural steroid injections and physical therapy. On December 10, 2008, Dr. Mitchell issued conflicting statements that claimant's restrictions were continued, but he was totally disabled. Dr. Malis issued 10-pound restrictions on January 19, 2009. Dr. Hattem determined that claimant was not at MMI and had five pound lifting restrictions. Dr. Mitchell recom-

mended surgery for the low back. On March 5, 2009, Dr. Hattem signed a Summary of Limitations form, indicating that claimant could work as a greeter. On March 19, 2009, Dr. Hattem noted that, per Dr. Mitchell, claimant should engage in no activity. Only on July 2, 2009, did Dr. Hattem determine that claimant was at MMI. The parties stipulated that MMI was not an issue in the current hearing.

28. Respondents have failed to prove by a preponderance of the evidence that claimant willfully misled the employer concerning his ability to perform the job of unloader and that the August 24, 2008, work injury resulted from the ability about which claimant willfully misled the employer. Claimant signed the acknowledgment that he could perform the job duties either with or without reasonable accommodations. He in fact performed the duties from November 27, 2007, through August 23, 2008, without any difficulties. Furthermore, the record evidence did not demonstrate that claimant had any specific work restrictions as of November 27, 2007.

29. Respondents have failed to prove by a preponderance of the evidence that the modified duty was offered to claimant on October 23, 2008. Claimant refused to receive a copy directly from the employer on that date. The employer sent the offer by certified mail. No certified mail return receipt was delivered. Claimant never had actual knowledge of the written offer of modified employment.

30. Respondents have failed to prove by a preponderance of the evidence that claimant was responsible for termination of his employment on December 4, 2008. The November 25 letter by Ms. Anslow merely asked claimant to respond as soon as possible if he intended to return to work for the employer. The thrust of the letter was to inform claimant that his FML had expired and that his extended leave of absence until December 4 did not prevent the employer from replacing him. Claimant was terminated due to his absence for his admitted work injury. He was not responsible for his termination of employment.

CONCLUSIONS OF LAW

1. Section 8-42-112(1)(d), C.R.S. provides that benefits shall be reduced fifty percent “Where the employee willfully misleads an employer concerning the employee’s physical ability to perform the job, and the employee is subsequently injured on the job as a result of the physical ability about which the employee willfully misled the employer.” As found, respondents failed to prove by a preponderance of the evidence that Claimant willfully misled the Employer concerning his physical ability to do the job of unloader. The 50% penalty request by the Respondents must be denied and dismissed.

2. Claimant was unable to return to the usual job due to the effects of the work injury. Consequently, claimant is “disabled” within the meaning of section 8-42-105, C.R.S. and is entitled to TTD benefits. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999); *Hendricks v. Keebler Company*, W.C. No. 4-373-392 (Industrial Claim Appeals Office, June 11, 1999). Claimant is entitled to TTD benefits if the injury caused a disability, the

disability caused claimant to leave work, and claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995).

3. Respondents argue that TTD benefits should be terminated effective October 23, 2008, pursuant to section 8-42-105(3)(d)(I), C.R.S. That section provides that TTD benefits terminate if "The attending physician gives the employee a written release to return to modified employment, such employment is offered to the employee in writing, and the employee fails to begin such employment." Respondents are correct that WCRP 6 deals only with unilateral termination of TTD benefits without a hearing. The statute controls the termination of TTD benefits at hearing. Respondents are correct that the statute requires only that the attending physician give a written release to return to modified employment. That was done on several occasions by Dr. Gray and Dr. Sacha. Nurse Practitioner Kletter, along with another unidentified person, signed the Summary of Limitations form. The statute does not require that this form must be signed by a physician. Nevertheless, as found, respondents have failed to prove that the modified duty was offered to claimant on October 23, 2008. A written offer of modified employment is not valid unless the claimant has actual knowledge of the offer. See *Owens v. Ready Men Labor, Inc*., W.C. No. 4-178-276, August 25, 1995, *aff'd*., *Ready Men Labor, Inc. v. Industrial Claim Appeals Office*, (Colo. App. No. 95CA1590, April 25, 1996) (not selected for publication). Where the offer is sent by certified mail, a presumption of receipt by the addressee arises if there is evidence of a certification and a signed return receipt. *Johnson v. Roark v. Associates*, 608 P.2d 818 (Colo. App. 1979). No such return receipt was delivered in this case.

4. Because claimant's injury was after July 1, 1999, sections 8-42-105(4) and 8-42-103(1)(g), C.R.S. apply. Those identical provisions state, "In cases where it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury." Sections 105(4) and 103(1)(g) bar reinstatement of TTD benefits when, after the work injury, claimant causes his wage loss through his own responsibility for the loss of employment. *Colorado Springs Disposal d/b/a Bestway Disposal v. Industrial Claim Appeals Office*, 58 P.3d 1061 (Colo.App. 2002). An employee is "responsible" if the employee precipitated the employment termination by a volitional act that an employee would reasonably expect to result in the loss of employment. *Patchek v. Colorado Department of Public Safety*, W.C. No. 4-432-301 (September 27, 2001). Thus, the fault determination depends upon whether claimant performed some volitional act or otherwise exercised a degree of control over the circumstances resulting in termination. *See Padilla v. Digital Equipment Corp.*, 902 P.2d 414 (Colo. App. 1994), *opinion after remand*, 908 P.2d 1185 (Colo. App. 1995). As found, respondents have failed to prove by a preponderance of the evidence that claimant was responsible for termination of his employment on December 4, 2008.

5. Because TTD benefits are not terminated, the issue of whether claimant suffered a change of condition since termination is moot.

ORDER

It is therefore ordered that:

1. Respondents' request for a 50% penalty pursuant to section 8-42-112(1)(d), C.R.S., is denied and dismissed.

2. Respondents' request to terminate TTD benefits effective October 23, 2008, is denied and dismissed.

3. Respondents' request to terminate TTD benefits effective December 4, 2008, is denied and dismissed.

4. All matters not determined herein are reserved for future determination.

DATED: October 14, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-734-158

ISSUES

The issues raised for consideration at hearing are: whether Claimant is entitled to an award of permanent partial disability benefits (PPD); what is Claimant's impairment rating; and whether Respondents are entitled to an award of penalties.

FINDINGS OF FACT

Having considered the evidence presented at hearing, the following Findings of Fact are entered.

1. Claimant alleged he sustained a work-related injury on August 7, 2007. The Insurer denied the claim. The matter went to hearing on January 15, 2008. During the hearing, Claimant alleged that he had work related injuries to his lungs, nasal passages, neck, shoulders and upper back on August 7, 2007. Claimant testified all of these body parts were injured August 7, 2007, at the Employer. Claimant submitted at hearing a report from Dr. Hall that suggests Claimant had work related neck, shoulder, thoracic injuries as well as wrist, elbow and headache problems.

2. Following the January 15, 2008, hearing, in a February 25, 2008, order ALJ Walsh adopted Respondents arguments that Claimant suffered a compensable injury limited to his right hand and wrist. It was further determined that any medical care is limited to Claimant's right wrist and right hand. This ALJ did not find treatment to any part of Claimant's body beyond the right wrist and right hand to be reasonable, necessary and related to the August 7, 2007, incident.

3. Claimant appealed this part of the ALJ's Order. Following an appeal, the Industrial Claim Appeals Office (ICAO) in their Final Order dated September 3, 2008, dismissed Claimant's Petition to Review "only insofar as it contests the portion of the ALJ's order confining the injury to the right hand and wrist." Following a second appeal, the ICAO in a Final Order dated February 12, 2009, stated "we dismissed the Claimant's petition to review insofar as it appealed the ALJ's Order that Claimant only injured his right hand and arm." The ALJ's decision limiting compensability to the right hand and right wrist is the law of the case. No other body part is compensable.

4. Claimant's attending physician, Dr. Hall, on December 22, 2008, placed Claimant at maximum medical improvement (MMI) and issued a permanent impairment rating for his right hand and right wrist, in addition to non-compensable body parts. Dr. Hall issued a 12% scheduled impairment for Claimant's wrist and hand. Impairment ratings for other body parts provided by Dr. Hall are irrelevant because the other body parts were determined not to be compensable.

5. Pursuant to Workers' Compensation Rules of Procedure, Rule 5-5, Respondents on February 5, 2009, filed an Application for Hearing contesting the scheduled impairment rating for Claimant's right hand and wrist. Respondents on the Application for Hearing identified other issues to be heard, which included "Claimant's entitlement to impairment rating for right wrist per ALJ Walsh." This hearing was initially set for June 4, 2009.

6. As discovery for the June 4, 2009, hearing concerning Claimant's entitlement to impairment rating for the right hand and right wrist per the ALJ's Order and Rule 5.5, Respondents requested Claimant attend an independent medical evaluation (IME) on April 15, 2009, with Dr. Wallace Larson. During his testimony, Claimant admitted he received the letter and knew of the appointment. Claimant failed to attend that examination. Claimant was able to attend that appointment and could have driven to that appointment. As a result of Claimant's failure to attend that examination, Respondents filed an Application for Penalties against Claimant for violation of Section 8-43-404(1), C.R.S. As a result of Claimant's failure to attend the examination, Respondents incurred fees charged by Dr. Larson.

7. In addition, Respondents filed a Motion to Compel Claimant to attend an IME with Dr. Larson. Prior to filing the Motion to Compel, Respondents notified Claimant of the second appointment scheduled with Dr. Larson on May 27, 2009. On May 7, 2009, ALJ Stuber entered an Order compelling Claimant to attend an IME with Dr. Larson on May 27, 2009. Claimant could have driven to the appointment, but did not at-

tend. Claimant had notice of the appointment and the ability to attend the appointment. Claimant failed to comply with that Order and failed to attend the IME with Dr. Larson on May 27, 2009. The ALJ's Order reflects the IME was construed as both discovery under Section 8-43-207(1), C.R.S. and a statutory examination under Section 8-43-404(1), C.R.S.

8. As a result of Claimant's failure to attend the IME, Respondents were granted an Order continuing the hearing from June 4, 2009, to July 28, 2009. The matter was then consolidated and scheduled for the hearing with the undersigned ALJ on August 28, 2009. And, again, Respondents incurred cancellation fees charged by Dr. Larson.

9. Claimant has not offered persuasive or credible reasons for his failure to comply with ALJ Stuber's Order. To the extent Claimant's testimony reflects he could not drive to this appointment or could not attend this appointment for financial reasons, that testimony is rejected as not credible.

10. In connection with the Administrative Hearing of August 28, 2009, Respondents served Claimant with Interrogatories on April 23, 2009. When Claimant failed to answer that discovery, Respondents filed a Motion to Compel on June 2, 2009. On June 16, 2009, an ALJ compelled Claimant to answer the interrogatories within seven days of the Order. Respondents' counsel sent Claimant's counsel a letter on June 29, 2009, reminding Claimant to answer the interrogatories. Claimant failed to comply with the Order until August 3, 2009.

11. Claimant has not offered any persuasive explanation for his refusal to comply with this discovery Order compelling him to answer interrogatories. To the extent Claimant's testimony or counsel's arguments articulate a reason for non-compliance, it is rejected as unpersuasive and incredible.

12. Claimant had notice that he could be sanctioned for his conduct. Respondents filed two Applications for Hearing seeking penalties and sanctions against Claimant for failing to fulfill his statutory obligations and for violating discovery Orders. Claimant also received a Motion for Summary Judgment concerning claim dismissal as a discovery sanction. Claimant had notice his conduct could result in claim dismissal.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following conclusions of Law are entered.

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of provid-

ing entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385, 389 (Colo. App. 2000).

I. Claimant's claim is dismissed as a discovery sanction.

3. Section 8-43-207(1)(e), C.R.S., provides that the director or ALJ "may rule on discovery matters and impose sanctions provided in the rules of civil procedure for willful failure to comply with permitted discovery." Because interrogatories and IME evaluations are a form of permitted discovery, (W.R.C.P. 9-1(A) & Section 8-43-404(1), C.R.S.), sanctions under Section 8-43-207(1)(e) are those similarly found in C.R.C.P. 37. *See Reed v. The Industrial Claim Appeals Office*, 13 P.3d 810 (Colo. App. 2000). In addition, ALJ Stuber's Order compelling attendance at the IME, specifically, refers to the discovery statute and, therefore, is an Order compelling discovery.

4. Pursuant to C.R.C.P. 37(b)(2):

> If a party…fails to obey an order to provide or permit discovery, including an order made under section (a) of this Rule or Rule 35 [Physical & Mental Examination of Persons], the court in which the action is pending may make such orders in regard to the failure as are just and among others the following: …
>
> (C) An order striking out pleadings or parts thereof, or staying further proceedings under the order is obeyed, or dismissing the action or proceeding or any part thereof, or rendering a judgment by default against the disobedient party.

5. Dismissal of a claim is permissible under the Workers' Compensation Act where "a party's disobedience of discovery orders is intentional or deliberate or if the party's conduct manifests either a flagrant disregard of discovery obligations or constitutes a substantial deviation from reasonable care in complying with discovery obligations." *Shied v. Hewlett Packard*, 826 P.2d 396 (Colo. App. 1991), *cert. denied* (1992).

6. Claimant asserts that he disobeyed the Administrative Law Judge's Order because he did not have transportation to Dr. Larson's IME. First, Claimant's lack of transportation to Dr. Larson's IME does not excuse his complete failure to obey the Administrative Law Judge's Order compelling him to answer interrogatories. Claimant's failure to answer interrogatories for more than three months, which necessitated a continuance, is willful and flagrant, and Claimant has offered no reasonable excuse to the contrary.

7. The ALJ is persuaded that Claimant's claim must be dismissed for his flagrant disregard in complying with discovery obligations and orders from this Court. First, Claimant failed to attend an IME with Dr. Larson despite his statutory obligation to do so under to Section 8-43-404(1), C.R.S. Respondents requested Claimant attend an IME on April 15, 2009, with Dr. Larson and Claimant knew of the examination and has admitted to not attending the examination. Second, Claimant failed to attend an IME with Dr. Larson even though this Court ordered him to do so. Claimant knew of this examination and failed to attend. The failure of Claimant to attend that examination caused a continuance and an additional hardship on Respondents by having to delay and postpone the issue of permanent partial disability benefits. Third, it is undisputed that Claimant failed to respond to Respondents' interrogatories for more than three months even though Claimant had been compelled by the Court. Further, Respondents incurred costs because Claimant failed to attend Dr. Larson's appointments.

8. Based on the evidence presented in this matter, it is established that Claimant failed to comply with multiple discovery requests from Respondents. Respondents requested the Court's involvement to compel Claimant for such discovery and Claimant has failed to obey such Orders. Claimant has remained disobedient and has neglected to perform or participate in his discovery obligations requested multiple times by Respondents and ordered by the Court. As a result, this claim has remained deadlocked thereby stalling resolution of the remaining claim issues causing delay and hardship on Respondents. Therefore, discovery sanctions such as claim dismissal is warranted as a matter of law pursuant to Section 8-43-207(1)(e) and C.R.C.P. 37 (b)(2)(C). Any other sanction and/or delay in the proceedings would be insufficient under the totality of the circumstances given Claimant's propensity to completely avoid his discovery obligations for this claim.

9. Because this ALJ is dismissing Claimant's claim with prejudice, Respondents request for penalties is denied. Claim dismissal is the appropriate sanction, and any further penalties would be duplicative. Having dismissed the claim, further penalties would not serve any purpose. In the event, the claims were not dismissed, this ALJ would have penalized Claimant because he failed to comply with various Orders previously described.

10. Claimant asserted he is entitled to permanent partial disability for all body parts rated by Dr. Hall, even those non-compensable, because Respondents did not request a Division IME. As noted above, claimant's compensable injuries are limited to his right hand and wrist. In any event, all of Claimant's arguments concerning permanent

partial disability are moot because, Claimant's claim is dismissed as a discovery sanction.

ORDER

It is therefore ordered that:

Claimant's claim is denied and dismissed with prejudice.

All matters not determined herein are reserved for future determination.

DATED: October 15, 2009

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-751-504

ISSUES

The issue for determination is whether or not Claimant's injury is one that is enumerated in the schedule set forth in §8-42-107 (1)(b) or whether the Claimant is entitled to a whole person medical impairment.

FINDINGS OF FACT

1. The Claimant sustained an admitted work related injury on February 14, 2008 when he fell approximately six feet off a tractor-trailer landing on his outstretched left hand.

2. The Claimant underwent the care and treatment of Dr. Thomas J. Blanchard, the Claimant's primary care physician, who referred the Claimant to Dr. Michael Hewitt.

3. An MRI was performed which showed a rotator cuff tear of the left shoulder along with a interior labral tear and shoulder showing a fusion extending into the bursa.

4. Surgery was performed on the Claimant on April 8, 2008 at which time a left shoulder arthroscopic rotator cuff repair was performed as well as an arthroscopic subacromial decompression with subtotal bursectomy, resection of the CA ligament and resection of an acromial spur.

5. Claimant stayed under Dr. Hewitt's care and treatment with ongoing physical therapy and repeat MRI examination until December 3,2 008.

6. MRI examination of December 3, 2008 showed that there was no full thickness retear of the rotator cuff but that there was thinning of the mid and posterior fibers of the rotator cuff.

7. Dr. Hewitt placed the Claimant at Maximum Medical Improvement on February 18, 2009 with a 6% upper extremity rating converting to a 4% whole person permanent impairment. Dr. Hewitt was of the opinion that the Claimant should have a gym membership for medical maintenance with orthopedic follow up one to two times over the course of the next year.

8. The Claimant's testimony indicated that he has pain across the front of his collarbone with limited movement when he moves his arm across the front of his chest and cramping in his neck. He further testified that he has pain across his trapezius muscle and that any motion with movement of his arm across his body causes spasms and pain in the trapezius muscle down his spine.

9. Claimant has difficulties with lifting and has pain into his collarbone associated with lifting activities.

10. The Claimant's testimony concerning the situs of the functional impairment of his injury as a result of the admittedly work related injury is credible and persuasive.

11. Claimant has proved by a preponderance of the evidence that his functional impairment is proximal to the glenohumeral joint and is entitled to benefits as a whole person medical impairment as the injury that he has sustained is not enumerated on the schedule set forth in Subsection of 8-42-107.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

1. General

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered “to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence.” See *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192, 1197 (Colo. App. 2002). The fact finder should consider, among other things, the consistency or inconsistency of a witness’ testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness’ testimony and/or actions; the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or

interest. See *Prudential Ins. Co. v. Cline,* 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil, 3:16 (2005). As found, Claimant's testimony meets the above tests of credibility.

b. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the entitlement to additional benefits beyond those admitted, including for a conversion from a scheduled award to a whole person award. Sections 8-43-201 and 8-43-210 C.R.S. (2008). See *City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000; *Lutz v. Industrial Claim Appeals Office*, 24 P.3d 29 (Colo. App. 2000). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probably, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.,* 104 P.3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. Also see *Ortiz v. Principi,* 274 F.3D 1361 (D.C. Cir. 2001). As found, Claimant has sustained his burden with respect to Dr. Hewitt's converted rating of 4% whole person.

2. SHOULDER CONVERSION

a. When an injury results in a permanent medical impairment not set forth on a schedule of disabilities, an employee is entitled to medical impairment benefits paid as a whole person. Section 8-42-107(8)(c), C.R.S. (2008). As found, the situs of Claimant's functional impairment is not listed on the schedule.

b. Section 8-42-107(1)(a) C.R.S. (2008), limits medical impairment benefits to those provided in section (2) where the Claimant's injury is one enumerated on the schedule. The schedule of injuries includes the loss of the "arm at the shoulder." The plain meaning of this is "at or below the shoulder." See Section 8-42-107(2)(a). The "shoulder" is not listed in the schedule of impairments. See *Martinez v. Albertsons,* W.C. No. 4-692-947 [Industrial Claim Appeals Office (ICAO), June 30, 2008]; *Maree v. Jefferson County Sheriff's Department,* W.C. No. 4-260-536 (ICAO, August 6, 1998); *Bolin v. Wacholtz,* W.C. No. 4-240-315 (ICAO, June 11, 1998). As found, the situs of Claimant's functional impairment is above the shoulder.

c. Although Section 8-42-107(2)(a) C.R.S. (2008) does not define a "shoulder" injury, the dispositive issue is whether the Claimant has sustained a functional impairment to a portion of the body listed on the schedule of disabilities. See *Strauch v. PSL Swedish Healthcare,* 917 P.2d 336 (Colo. App. 1996). The ALJ is tasked with determining the situs of functional impairment, not necessarily the situs of the initial harm, in deciding whether the loss is one listed on the schedule of disabilities or not. As found, the situs of Claimant's functional impairment is not listed on the schedule of disabilities. It is on top of the Claimant's left shoulder not at or below the shoulder.

d. Pain and discomfort which limit a Claimant's ability to use a portion of the body can be considered functional impairment for purposes of determining whether an injury is off the schedule. See *Langton v. Rocky Mountain Healthcare Corp.,* 937 P.2d 883 (Colo. App. 1996) *Eidy v. Pioneer Freightways,* W.C. No. 4-291-940 (ICAO, August

4, 1998); *Beck v. Mile Hi Express, Incorporated,* W.C. No. 4-238-483 (ICAO, February 11, 1997). Not only does Claimant experience pain on top of the left shoulder, above the situs of the surgery, the top of his left shoulder is functionally limited from regarding Claimant's job activities. Claimant suffers pain at the top of his shoulder that limits his ability to perform the function of carrying objects on his shoulder, lifting above the head, and sleeping. Claimant's functional impairment is above the arm at the shoulder, and not on the schedule of impairments. See *Phase II Company v. ICAO,* (Colo. App. No. 97 CA2099, September 3, 1998) [NSOP]. As found, the presence of pain, discomfort and loss of function is to the structures beneath the top of his shoulder, not the arm.

e. There is substantial evidence that Claimant suffered functional impairment beyond, or above, the arm at the shoulder**.** *City Market v. ICAO* , 68 P.3d 601 (Colo. App. 2003). Specifically, Claimant suffers functional loss to areas of the shoulder joint, both of which are beyond the arm and at the shoulder. Thus, a whole person award is appropriate. See *B. v. City of Aurora*, W.C. No. 4-452-408 (ICAO, October 9, 2002).

f. As found, Claimant's shoulder causes pain and reduced function in structures that are above the shoulder joint. Thus, Claimant's injury should be compensated, based on a whole person because the situs of his functional impairment is off the schedule. See *Velasquez v. UPS,* W.C. No. 4-573-459 (CAO April 13, 2006) *Heredia v. Marriot,* W.C. o. 4-508-205 (ICAO, September 17, 2004); see also *Smith v. Neoplan USA Corporation,* W.C. No. 4-421-202 (ICAO, October 1, 2002); *Colton v. Tire World,* W.C. 4-449-005 (ICAO, April 11, 2002); *Guillotte v. Pinnacle G lass Company*, W.C. No. 4-443-878 (ICAO, November 20, 2001); *Copp v. City of Colorado Springs,* W.C. No. 4-271-758; 4-337-778 (ICAO, January 24, 2001); *Olson v. Foley's*, W.C. No. 4-326-898 (ICAO, September 12, 2000); *Gonzales v. City and County of Denver,* W.C. No. 4-296-588 (ICAO, September 10, 1998).

ORDER

1. Respondents shall pay Claimant medical impairment benefits of 4% from the date of maximum medical improvement of February 18, 2009.

2. Respondents shall receive a credit against such physical impairment benefits for any scheduled benefits previously paid by the Respondents to the Claimant.

3. Claimant shall receive interest at the rate of 8% per annum for all amounts not paid when due.

DATED: October 15, 2009

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-780-115

ISSUES

The following issues were raised for consideration at hearing: compensability, medical benefits and temporary disability benefits.

STIPULATION

The parties filed a Stipulation that was approved by this ALJ indicating that if the claim were deemed compensable, respondents would admit for temporary total disability benefits from January 12, 2009 through January 22, 2009 and for temporary partial disability benefits from January 23, 2009 through February 23, 2009. The parties also stipulated to an AWW of $642.95. The parties stipulated further that In the event claimant seeks TTD or TPD benefits in the future beyond the closed period of time agreed upon by this stipulation, respondents may pursue a defense that claimant was responsible for his termination pursuant to Section 8-42-105(4). Testimony from Employer witness Alison Larsen was not considered.

FINDINGS OF FACT

1. Claimant contends that on Friday, December 5, 2008, at about 10:30 a.m., he experienced sharp right groin pain after lifting two large 5-gallon paint cans up stairs at work. Claimant admits there were no witnesses. Claimant contends that Rolando Flores was working with him all day before and after the alleged injury but claimant did not mention the alleged injury to Rolando Flores because claimant "thought it was some personal problem."

2. Claimant claims that he telephoned foreman M on Monday, December 8, 2008, but that M did not answers his telephone. Claimant does not contend that he left a message for M but instead, he allegedly called a co-worker to discuss the hernia. Claimant testified that he did not like to leave messages on machines for people.

3. According to M's testimony, claimant did not work on December 8 or 9, 2009. This was not unusual because claimant previously missed work on Mondays and/or Tuesdays due to weekend activity.

4. M testified that he first saw claimant after December 5, 2008, the following Wednesday, December 10, 2008. Claimant appeared for daily early morning stretching exercises stating the he could not participate in the stretching exercise or work because of pain. M observed that claimant appeared stiff and had difficulty moving. M asked claimant what was wrong and claimant stated that he injured himself the previous Friday, December 5, 2008, while carrying buckets of paint up stairs.

5. M also testified that claimant telephoned him on Sunday, December 7, 2008, 2-days after the alleged injury, and invited M to a birthday party. During this phone call, claimant made no mention of the alleged hernia he sustained at work 2-days before inviting M to a party.

6. Claimant testified that on Sunday, December 7, 2008, he was in so much pain that his daughter drove him around the neighborhood trying to locate a medical facility that was open on Sunday. Claimant's testimony is not credible.

7. Claimant claimed that he has "never had any other injuries to my hernia or groin in my life." Dr. Gellrick documented that she asked claimant twice about pre-existing hernias and claimant twice denied having any pre-existing hernia or groin problems. Claimant's testimony is not credible.

8. M testified that claimant told him he sustained a hernia a year or two before the alleged work injury possibly while lifting sheet rock. Claimant denied having a pre-existing hernia. M testified that claimant may have injured himself at work because he was a hard worker, but M does not know if claimant injured himself at work. The ALJ finds M's testimony credible.

9. On December 16, 2008, Employer filed a First Report of Injury indicating that claimant reported on December 15, 2008 that he was carrying 10 pounds of paint up stairs and felt pain.

10. On December 17, 2008, Employer completed an accident/loss investigation report indicating that claimant reported that he noticed a bump in his right groin which occurred 2 years prior while claimant was working with sheetrock.

11. Claimant was seen by David Beck, M.D. On January 6, 2009, Dr. Beck reported that claimant presented with a "bulge for 1 year Location; right groin, reduces spontaneously, aggravated by: exercise, Relieved by: rest." No mention is made of an alleged work injury involving claimant lifting 10-gallon paint cans while walking up stairs at work for Employer.

12. A handwritten medical note from Dr. Beck's office indicates that claimant was seen on December 12, 2008 and was: "also concerned about a hernia (inguinal) that he's had for many years – recently started hurting approximately one week ago."

13. Dr. Beck did not have a specific recollection of his first visit with claimant but he is sure that a Spanish/English speaking interpreter was present because Dr. Beck does not speak Spanish and Dr. Beck documented that claimant speaks very little English. The interpreter could have been somebody from Dr. Beck's office as a couple of his staff are fluent in Spanish or it may have been a friend or family member that claimant brought along to the appointment.

14. The history documented by Dr. Beck is that claimant had groin pain/hernia for a year that was aggravated by exercise and that reduces spontaneously, which means that the bulge or lump in claimant's groin would go away. At the time he first saw claimant, Dr. Beck had not reviewed any medical records from any other physician.

15. Dr. Beck testified that he would not have documented a one-year pre-existing hernia unless claimant provided this history to him. According to Dr. Beck's testimony, claimant's hernia was pretty large and based on it's size, regardless of the history provided by claimant, Dr. Beck suspected that the hernia was present for at least six months and possibly as long as many years.

16. Dr. Beck testified that a pre-existing hernia could be aggravated by lifting 5 gallon paint cans, but he was unaware that claimant was claiming that the hernia was caused by a work injury, and he did not recall claimant reporting an injury occurred in December of 2008 while lifting paint cans at work. If claimant provided this history to Dr. Beck, Dr. Beck most likely would have written it down. According to Dr. Beck's testimony, a pre-existing hernia could also be aggravated by exercise and wide activity, meaning anything that's not rest, which could be as simple as walking or going up stairs.

17. Dr. Beck testified that he generally recommends fixing all hernias, including inguinal hernias (even if the hernia is not symptomatic) as soon as the existence of the hernia becomes known because hernias are not going to get better with time and could potentially get worse.

18. On December 23, 2008, Edward Medina, M.D. reported that claimant "does note that he may have noticed a bulge in his groin in the past when lifting heavy sheetrock."

19. Claimant denied having a hernia or groin pain or noticing a bulge prior to December 8, 2008. According to claimant's testimony, the term 'hernia" was not familiar to him so he would not have used the term. Claimant also testified that the medical providers who documented a history from claimant of having a previous hernia may have mistaken claimant's complaints of indigestion and stomach problems. This testimony is not credible and is inconsistent with the testimony from M who testified that he recalled claimant telling him he had a pre-existing hernia and that claimant used the term hernia more than once before December 5, 2008, when he was officially diagnosed.

20. Claimant was seen by F. Mark Paz, M.D. for an IME accompanied by a Spanish/English interpreter named Franco. Claimant provided a history to Dr. Paz that he had no symptoms or abnormalities in the right groin region prior to the December 5, 2008 work injury.

21. Claimant's testimony is also inconsistent with testimony from Dr. Paz who explained that claimant would have noticed the bulge in his groin and that the symptoms caused by indigestion are not in any way consistent with groin pain.

22. Dr. Paz testified that he agreed with Dr. Beck that based upon the size of claimant's hernia upon diagnosis, claimant's hernia was likely present prior to December 5, 2008. Dr. Paz also testified that he agreed with Dr. Beck that hernia surgery is reasonable and necessary at the time the hernia is caused even if it is asymptomatic. Dr. Paz explained that even if an incident did occur at work on December 5, 2008, the incident did not cause the need for any medical treatment, including surgery. Nor would the incident have rendered claimant disabled or have resulted in a substantial and permanent aggravation of claimant's pre-existing hernia.

23. Dr. Paz credibly testified that even if the incident increased claimant's symptoms, it is no different than claimant's symptoms being aggravated for the past 1 to 2 years by exercise and relieved by rest as documented in Dr. Beck's notes. The increase in symptoms would not be permanent, nor would it have caused the need for medical treatment, including surgery.

24. Dr. Paz explained that claimant underwent elective hernia surgery. This is the same surgery claimant should have had and that was reasonable, necessary and related to the pre-existing hernia and not an event that may or may not have occurred on December 5, 2008. If an event of December 5, 2008 occurred which would have caused a substantial and permanent aggravation of claimant's pre-existing hernia, claimant would have required emergency hernia surgery or he could have died from the condition. This did not occur and the surgery, which claimant was a candidate for prior to December 5, 2008, was elective.

25. Dr. Paz also testified that there was no indication that claimant's hernia was the result of an occupational disease and the medical evidence in this claim does not support such a finding. The ALJ is persuaded by the credible opinions provided by Dr. Paz and Dr. Beck.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following Conclusions of Law are entered.

Credibility

a. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See* Prudential Insurance Co. v. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

b. As found, testimony from claimant was contradicted by testimony from Roel M and the persuasive opinions of Dr. Paz and Dr. Beck. The ALJ credits the medical opin-

ions of Dr. Paz and Dr. Beck and the testimony of M. Their opinions are persuasive and supported by the record. Claimant is not credible.

Compensability

c. For a claim to be compensable, claimant has the burden of proving that he suffered a disability that was proximately caused by an injury or that he needs medical treatment. §8-41-301(1)(c) C.R.S.; in *re Swanson,* W.C. No. 4-589-645 (ICAP, Sept 13, 2006). Claimant failed to prove either element. Claimant failed to meet his burden of proving a work injury occurred on December 5, 2008.

d. Even if claimant experienced pain from his previous hernia (which he denies having) or other pre-existing condition, the claim is not compensable. A traumatic incident or event which merely elicits pain symptoms does not compel a finding that the claimant sustained a compensable aggravation or new injury. See F.R. Orr Construction v. Rinta, 717 P.2d 965, (Colo. App. 1985); Witt v. Keil, W.C. No. 4-225-334 (Apr. 7, 1998).

e. Compensability is also not established unless claimant proves the need for medical treatment is a "[N]atural and proximate consequence of the . . . industrial injury, without any contribution from a separate, causative factor." Valdez v. United Parcel Serv., 728 P.2d 340 (Colo. App. 1986) The failure to establish a causal connection between the injury and the need for medical treatment is fatal to a claim for compensation. Kinninger v. Industrial Claims Appeal Office, 759 P.2d 766 (Colo. App. 1988). To establish the causation connection, claimant must establish that the need for "medical treatment is proximately caused by the injury, and is not simply a direct and natural consequence of the pre-existing condition" or subsequent injury. Witt, at *1(citing Merriman v. Indus. Comm., 210 P.2d 448, 450 (Colo. 1949); Rockwell International v. Turnbull, 802 P.2d 1182 (Colo. App. 1990)).

f. Based upon the medical records, the testimony and reports of Dr. Paz and claimant's incredibility, the ALJ find that the alleged work injury is not compensable.

g. Claimant bears the burden to prove his entitlement to medical benefits. Gerloff v. Meeker School District Re 1, W.C. Nos. 4-327-138 and 3-108-777 (ICAO May 3, 1999). Claimant must show that the disputed medical treatment is authorized and reasonably necessary to cure or relieve the effects of the injury covered by this claim. Claimant cannot meet this burden.

h. According to Dr. Paz, the hernia surgery was reasonable and necessary and related to the hernia which pre-existed the alleged December 5, 2008 injury. Even if the December 5, 2008 injury occurred and aggravated a pre-existing condition, hernia surgery is not performed to treat symptoms; it is performed to correct the problem/bulge that will not go away by any other means but surgery. This is consistent with Dr. Beck's testimony that the hernia should have been corrected when it occurred even if it was asymptomatic because hernias do not improve with time and could potentially worsen. The ALJ is persuaded that claimant had a hernia prior to December 5, 2008 and that the need for surgery was related to the pre-existing condition and not the alleged December 5, 2008 injury.

ORDER

It is therefore ordered that Claimant's claim for compensability is denied and dismissed.

DATED: October 15, 2009

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-790-101

ISSUES

Whether Claimant is entitled to a change of physician to Dr. Joseph Ramos based upon Respondents' failure to timely respond to a request for change of physician made pursuant to Section 8-43-404(5)(a)(VI), C.R.S.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant sustained an injury on March 16, 2009. Claimant was driving a truck for Employer when he vehicle was hit head on by another truck that had crossed the centerline of the highway.

2. Following his injury Claimant was referred by Employer to Dr. Suzanne Beck, M.D. for treatment. Dr. Beck subsequently referred Claimant to Dr. John Sacha, M.D. and Dr. Ron Carbaugh, Psy. D. for further treatment.

3. On April 29, 2009 Claimant's counsel mailed a packet of correspondence and documents addressed to Boeving at AIG Domestic Claims in Shawnee Mission, Kansas. Ms. Boeving was at that time the adjuster assigned by Insurer to handle Claimant's claim for benefits. This packet of correspondence and documents was received by Insurer on May 4, 2009.

4. The top page of the packet of documents mailed to Insurer on April 29, 2009 by Claimant's counsel was a cover letter forwarding a copy of a medical report from Dr. Beck dated April 17, 2009. The second page of the packet was the April 17, 2009 M-164 report from Dr. Beck.

5. The third page of the packet of documents mailed to Insurer by Claimant's counsel on April 29, 2009 was a second letter addressed to Ms. Boeving. The letter stated that it was in regards to "Entry of Appearance/Letter of Representation". The first paragraph of the letter discussed that Claimant's counsel had been retained to repre-

sent Claimant and requested copies of Insurer's file, wage records and any General or Final Admissions of Liability. The last sentence of this first paragraph stated: "We would like our client's care to be transferred to Dr. Joseph Ramos."

6. Neuser is a lost-time adjuster for Insurer. She took over handling of Claimant's claim on May 5, 2009. Ms. Neuser reviewed the packet of documents and correspondence mailed by Claimant's counsel on April 29, 2009 and determined that she had previously received a copy of the April 17, 2009 M-164 report from Dr. Beck. Ms. Neuser did not think anything else was enclosed when she read the cover letter dated April 29, 2009 forwarding the April 17, 2009 report from Dr. Beck although, as Ms. Neuser testified, the packet of correspondence and documents had all been mailed in one envelope and had arrived and been scanned into Insurer's system in the order that they appear in Exhibit G, i.e. that the second letter of April 29, 2009 addressed to Ms. Boeving and containing the statement "We would like our client's care to be transferred to Dr. Joseph Ramos" was the third document in the packet.

7. On June 2, 2009 Claimant's counsel wrote to Ms. Neuser noting that on April 29, 2009 a letter had been sent requesting Claimant's care to be transferred to Dr. Ramos. Claimant's counsel further stated that since 20 days had elapsed since the April 29, 2009 letter and no response had been received Dr. Ramos should now be considered the authorized treating physician.

8. Insurer received Claimant's counsel's June 2, 2009 letter on June 4, 2009. On that date, Ms. Neuser mailed a letter to Claimant's counsel denying the request to change physicians to Dr. Ramos.

9. Ms. Neuser did not become aware of the Claimant's request for a change of physician until her receipt of Claimant's counsel's June 4, 2009 letter. While Ms. Neuser was not herself aware of the request until June 4, 2009 the Insurer had received Claimant's request on May 4, 2009. Ms. Neuser acknowledged, and it is found, that it is her job as a lost-time adjuster to review every document that is received. Insurer had actual knowledge of Claimant's request to change physicians as of May 4, 2009 when it received Claimant's counsel's letter of April 29, 2009 containing the request.

10. Claimant's request for a change of physicians to Dr. Ramos was mailed to Insurer on April 29, 2009. Insurer did not deny or otherwise respond to this request within 20 days of the date the request was mailed. Insurer waived any objection to Claimant's request for a change of physicians to Dr. Ramos. Dr. Ramos became the authorized treating physician as of May 20, 2009, the first day after expiration of Insurer's 20 day period to object or respond to Claimant's request for a change of physician.

CONCLUSIONS OF LAW

11. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of

litigation. Section 8-40-102(1), C.R.S. The claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979) The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the claimant nor in favor of the rights of respondents and a workers compensation claim shall be decided on its merits. Section 8-43-201 (2008) C.R.S.

12. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

13. Section 8-43-404(5)(a)(VI), C.R.S. provides:

> "In addition to the one-time change of physician allowed in subparagraph (III) of this paragraph (a), upon written request to the insurance carrier or to the employer's authorized representative if self-insured, an injured employee may procure written permission to have a personal physician or chiropractor treat the employee. If permission in neither granted or refused within twenty days, the employer or insurance carrier shall be deemed to have waived any objection to the employee's request."

14. The time period for an insurer to respond to a request for change of physician pursuant to Section 8-43-404(5)(a)(VI), C.R.S. begins upon date of the mailing of the request, not upon the date of receipt. *Gianetto Oil Company v. Indus. Claim Appeals Office,* 931 P.2d 570 (Colo. App. 1996). The request for a change of physicians pursuant to Section 8-43-404(5)(a)(VI), C.R.S. does not have to be in any particular form or include any particular language but must be a request and not a unilateral declaration of intent to change physicians. *Lutz v. Indus. Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000, cert. denied 2001). Although no particular form or language is required, the request may not be ambiguous. *Brown & Root, Inc. v. Indus. Claim Appeals Office,* 833 P.2d 780 (Colo. App. 1991). A Claimant need not seek the insurance carriers' permission to change physician if the change is to a physician within the "chain of referral" from another authorized physician. *Greager v. Indus. Comm'n,* 701 P.2d 168 (Colo. App. 1985).

15. As found, Claimant requested a change of physicians to Dr. Ramos in a letter that was mailed to Insurer on April 29, 2009. Insurer did not object or otherwise respond to the letter within 20 days and therefore waived any objection to the request. Claimant's counsel's letter of April 29, 2009 contained a proper request for a change of physician in that it was phrased in the form of a desire on the part of the Claimant to have his care transferred to Dr. Ramos as opposed to a unilateral statement that Claimant would be treating with Dr. Ramos. Claimant's request for a change of physicians was unambiguous. Respondents' argument that Ms. Neuser was not aware of the re-

quest until June 4, 2009 and then timely denied the request does not afford Respondents a basis to object to the change of physicians under the facts here. As noted above, the time period for responding to a written request for a change of physician begins to run as of the date of mailing of the request, not when Insurer receives or becomes aware of the request. Respondents' further argument that the request was "buried" in other correspondence is not persuasive and likewise does not provide a basis for Respondents to avoid the change of physicians to Dr. Ramos under the facts. Ms. Neuser admitted that it was her obligation to review every piece of correspondence received by the Insurer on Claimant's claim. While it is true that the request here was contained in a letter that was part of a packet of multiple documents sent to Insurer, the request was not ambiguously stated and was contained in a paragraph making other requests to the Insurer. As testified by Ms. Neuser, it was her job to review any correspondence to ascertain if it contained language such as a request for a change of physician. In this instance, Ms. Neuser failed to do so and as a result did not timely respond to the request and thereby waived Insurer's objection to the requested change of physician to Dr. Ramos.

ORDER

It is therefore ordered that:

Claimant's request for a change of physician to Dr. Joseph Ramos, M.D. is GRANTED.

All matters not determined herein are reserved for future determination.

DATED: October 16, 2009

Ted A. Krumreich

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-769-902

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she suffered a disc herniation during the course and scope of her employment with Employer on August 21, 2008.

2. Whether Claimant has demonstrated by a preponderance of the evidence that she is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

3. A determination of Claimant's Average Weekly Wage (AWW).

4. Whether Claimant has proven by a preponderance of the evidence that she is entitled to receive Temporary Total Disability (TTD) benefits.

5. Whether Claimant has demonstrated by a preponderance of the evidence that she is entitled to recover penalties pursuant to §8-43-304(1), C.R.S. for Respondents' violation of WCRP 16.

6. Whether Claimant is entitled to a disfigurement award pursuant to §8-42-108, C.R.S.

FINDINGS OF FACT

1. Claimant worked for Employer as a Zone Manager. Her duties involved ensuring that resort properties were properly cleaned and stocked with supplies.

2. Claimant has suffered from lower back problems since she sustained an industrial injury while working for a previous employer in February 2008. She experienced a recurrence of lower back pain and underwent a microdiscectomy on August 8, 2008 with Eric R. Jamrich, M.D. The surgery was unrelated to her employment activities for Employer.

3. Dr. Jamrich released Claimant to light duty work for Employer on August 18, 2008. Although Claimant experienced some soreness, she completed her job duties. Claimant did not return to work on August 19-20, 2008 because they were her scheduled days off.

4. On August 21, 2008 Claimant reported for her scheduled work shift. Claimant explained that she proceeded to review condominium units in the Emerald Lodge building and noticed that a housekeeper had not properly stocked supplies under the kitchen sink in one of the units. While reaching under the sink to replace supplies Claimant bent down and experienced a sharp pain in her lower back. She lost her balance and fell backwards onto her buttocks on a slate tile floor. Claimant then experienced pain in her spine area. She was unable to get up and crawled from the kitchen to the living room area in order to pull herself up using a piece of furniture.

5. Claimant stated that she reported her lower back injury to supervisor Thompson. However, Ms. Thompson did not refer Claimant for medical treatment. Claimant then went home.

6. Claimant returned to work on August 22, 2008 but was unable to perform her job duties. She visited the Emergency Room at Yampa Valley Medical Center for treatment. An MRI of Claimant's lower back revealed a recurrent disc herniation.

7. On August 25, 2008 Claimant's supervisor Thompson completed an injury report. She noted that Claimant had been injured on August 21, 2008, went to an emergency room on August 22, 2008 and subsequently traveled to Denver for surgery.

8. On August 25, 2008 Claimant visited Dr. Jamrich with symptoms of recurrent left lumbosacrial pain that radiated into her left leg. She also mentioned lower back and right leg pain. Claimant was extremely uncomfortable and was experiencing significant leg weakness. Dr. Jamrich noted that recurrent disc herniations are typically more painful than initial disc herniations because of surgical scarring and the pressure of the disc herniation on the nerve root.

9. On August 25, 2008 Dr. Jamrich attempted to perform fusion surgery. However, after Dr. Jamrich began the fusion procedure he discovered pus in the area of the herniated disc. He thus abandoned the procedure, performed a discectomy and referred Claimant to an infectious disease consultant for medical treatment of her infection. Because medical providers determined that Claimant was suffering from a staph infection, she underwent IV antibiotic treatment for several weeks. During the period Claimant remained off of work.

10. On September 26, 2008 Insurer filed a Notice of Contest challenging Claimant's claim for compensation. Insurer's Claims Specialist Orozco testified through an evidentiary deposition in this matter. Ms. Orozco stated that she denied the claim because she questioned the causation of Claimant's injury. She explained that she had written a letter to Dr. Jamrich asking him to address the causation of Claimant's condition but he did not respond to the request.

11. On November 4, 2008 Dr. Jamrich FAXed a prior authorization request to Ms. Orozco seeking approval to complete fusion surgery on Claimant. He specified that he would perform a posterior lumbar interbody spine fusion at L4-L5 on November 10, 2008. The prior authorization request was hand-written on a FAX cover sheet that did not explain the medical necessity of the requested procedure or how the procedure was causally related to a work injury.

12. On November 10, 2008 Dr. Jamrich contacted Ms. Orozco to determine why the requested surgery had not been authorized. Ms. Orozco responded that the surgery had not been authorized because of her concerns regarding the causation of Claimant's injury. Ms. Orozco testified that Dr. Jamrich then explained that Claimant's August 8, 2008 surgery had caused an infection. The infection caused the disc to collapse and created a recurrent herniation. Ms. Orozco then advised Dr. Jamrich that the August 8, 2008 surgery was not the basis of the workers compensation claim. Dr. Jamrich responded that he understood why the surgery was not authorized and sought authorization from Claimant's health insurance carrier.

13. On November 12, 2008 Dr. Jamrich completed Claimant's fusion surgery. Claimant remained off of work through December 26, 2008.

14. On December 16, 2008 Hugh H. Macaulay, M.D. conducted an independent medical examination of Claimant. He concluded that Claimant's recurrent disc herniation was not related to her August 21, 2008 work incident. Dr. Macaulay also testified at the hearing in this matter. He explained that Claimant's August 8, 2008 surgery caused a staph infection that ultimately resulted in Claimant's disc herniation. He ex-

plained that the changes in Claimant's August 22, 2008 MRI were indicative of tissue expansion or granulation. Dr. Macaulay commented that the infection would have caused a weakening of the disc structure in Claimant's back. He remarked that it was speculative to attempt to determine the timing of Claimant's disc changes because she had been suffering from a soft tissue infection. Finally, Dr. Macaulay remarked that any falls of less than three feet are unlikely to cause a disc herniation.

15. On September 14, 2009 the parties conducted the evidentiary deposition of Dr. Jamrich. He concluded that Claimant's recurrent disc herniation was caused by her slip and fall at work on August 21, 2008. Dr. Jamrich explained that Claimant's staph infection did not cause her disc herniation because there was no evidence of a deep infection on Claimant's August 22, 2008 MRI. He emphasized that the recurrent disc herniation was not directly related to the infection and that he was "quite surprised" to notice the infection during the August 25, 2008 surgery. Dr. Jamrich also commented that Claimant's explanation of the mechanism of injury was consistent with a recurrent disc herniation.

16. Dr. Jamrich also testified about his conversation with Ms. Orozco. He stated that he told Ms. Orozco "given the infection here, that it was appropriate—it was absolutely appropriate to stabilize this," and also "if they had it in their records that this wasn't a work comp injury, then we would get approval from her medical carrier." He subsequently wrote a letter to Ms. Orozco stating that the November 10, 2008 surgery was related to the work injury and was reasonable and necessary because of the instability caused by the August 25, 2008 surgery. However, Ms. Orozco testified that she did not actually receive the letter until after the November 12, 2008 surgery.

17. Claimant has failed to demonstrate that it is more probably true than not that she suffered a compensable herniated disc during the course and scope of her employment with Employer on August 21, 2008. Her employment activities on August 21, 2008 did not aggravate, accelerate, or combine with her pre-existing back problems to produce a need for medical treatment. Dr. Macaulay's persuasive testimony reflects that Claimant's recurrent disc herniation and need for surgery was related to an infection caused by her August 8, 2008 non-work-related surgery. Dr. Macaulay credibly commented that the changes in Claimant's August 22, 2008 MRI were indicative of tissue expansion or granulation. He explained that the infection would have caused a weakening of the disc structure in Claimant's back. Dr. Macaulay remarked that it was speculative to attempt to determine the timing of Claimant's disc changes because she had been suffering from a soft tissue infection. In contrast, Dr. Jamrich determined that Claimant's recurrent disc herniation was caused by her slip and fall at work on August 21, 2008. However, his testimony is not persuasive because it fails to adequately account for the staph infection that he discovered on August 25, 2008. Moreover, based on the sequence of events beginning with Claimant's August 8, 2008 surgery, it is speculative to attribute Claimant's recurrent disc herniation to her April 21, 2008 work activities.

18. Claimant has failed to prove that it is more probably true than not that she is entitled to recover penalties from Respondents. Dr. Jamrich's November 4, 2008 request for prior authorization did not comply with the requirements of WCRP 16-9(E). WCRP 16-9(E) states that in order to complete a prior authorization request, a provider must concurrently explain the medical necessity of the services requested and produce relevant supporting medical documentation. The November 4, 2008 request contained no explanation for the requested surgical procedure but merely sought authorization. Claimant has also failed to present supporting documentation used in Dr. Jamrich's decision-making process to substantiate the need for the procedure or the medical necessity of the requested procedure. The record reveals that the last communication between Insurer and Dr. Jamrich's office prior to November 4, 2008 was an October 14, 2008 letter from Ms. Orozco asking Dr. Jamrich to address the connection between Claimant's recurrent herniation and her August 21, 2008 work activities. None of Dr. Jamrich's medical records prior to October 14, 2008 addressed Ms. Orozco's concern and Dr. Jamrich did not respond to Ms. Orozco's concerns in the November 4, 2008 written request for authorization. Because the request for prior authorization did not comply with the requirements of WCRP 16-9(E), Claimant has failed to establish that Respondents violated a Rule. Therefore, Claimant's request for penalties is denied.

19. As a result of Claimant's November 12, 2008 surgery she incurred a scar on her lower back that is approximately six inches long and one-eighth inch wide. However, because Claimant's scarring from her November 12, 2008 surgery was not related to her August 21, 2008 employment activities, she is not entitled to a disfigurement award.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has failed to demonstrate by a preponderance of the evidence that she suffered a compensable herniated disc during the course and scope of her employment with Employer on August 21, 2008. Her employment activities on August 21, 2008 did not aggravate, accelerate, or combine with her pre-existing back problems to produce a need for medical treatment. Dr. Macaulay's persuasive testimony reflects that Claimant's recurrent disc herniation and need for surgery was related to an infection caused by her August 8, 2008 non-work-related surgery. Dr. Macaulay credibly commented that the changes in Claimant's August 22, 2008 MRI were indicative of tissue expansion or granulation. He explained that the infection would have caused a weakening of the disc structure in Claimant's back. Dr. Macaulay remarked that it was speculative to attempt to determine the timing of Claimant's disc changes because she had been suffering from a soft tissue infection. In contrast, Dr. Jamrich determined that Claimant's recurrent disc herniation was caused by her slip and fall at work on August 21, 2008. However, his testimony is not persuasive because it fails to adequately account for the staph infection that he discovered on August 25, 2008. Moreover, based on the sequence of events beginning with Claimant's August 8, 2008 surgery, it is speculative to attribute Claimant's recurrent disc herniation to her April 21, 2008 work activities.

Penalties

7. Section 8-43-304(1), C.R.S. is a general penalty provision under the Act that authorizes the imposition of penalties up to $500 per day where a party violates a statute, rule, or lawful order of an ALJ. *Holliday v. Bestop, Inc.,* 23 P.3d 700, 705, 706 (Colo. 2001). The term "order" as used in §8-43-304 includes a rule or regulation promulgated by the Director of the Division of Worker's Compensation. §8-40-201(15), C.R.S.; *see Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176, 177 (Colo. App. 2002).

8. The imposition of penalties under §8-43-304(1) requires a two-step analysis. *See In re Hailemichael,* W.C. No. 4-382-985 (ICAP Nov. 17, 2004). The ALJ must first determine whether the disputed conduct violated a provision of the Act or rule. *Allison v. Industrial Claim Appeals Office,* 916 P.2d 623, 624 (Colo. App. 1995). If a violation has occurred, penalties may only be imposed if the ALJ concludes that the violation was objectively unreasonable. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office,* 907 P.2d 676, 678-79 (Colo. App. 1995). The reasonableness of an insurer's actions depends upon whether the action was predicated on a "rational argument based on law or fact." *In re Lamutt,* W.C. No. 4-282-825 (ICAP, Nov. 6, 1998).

9. Claimant seeks penalties against Respondents for violations of WCRP 16-9 and 16-10. WCRP 16-9(B) and WCRP 16-10(A) provide, in relevant part, that the payer shall respond to all providers requesting prior authorization within seven business days from receipt of the "provider's completed request as defined in Rule 16-9(E)." WCRP 16-9(E) specifies:

> To complete a prior authorization request, the provider shall concurrently explain the medical necessity of the services requested and provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested services or procedure.

WCRP 16-10(E) provides that the failure of a payer to timely respond to a request for prior authorization shall be "deemed authorization for payment" unless a hearing is requested or the requesting provider is notified that the matter is proceeding to a hearing. Finally, WCRP 16-10(F) specifies that any "unreasonable delay or denial of prior authorization" may subject the payer to penalties.

10. As found, Claimant has failed to prove by a preponderance of the evidence that she is entitled to recover penalties from Respondents. Dr. Jamrich's November 4, 2008 request for prior authorization did not comply with the requirements of WCRP 16-9(E). WCRP 16-9(E) states that in order to complete a prior authorization request, a provider must concurrently explain the medical necessity of the services requested and produce relevant supporting medical documentation. The November 4, 2008 request contained no explanation for the requested surgical procedure but merely

sought authorization. Claimant has also failed to present supporting documentation used in Dr. Jamrich's decision-making process to substantiate the need for the procedure or the medical necessity of the requested procedure. The record reveals that the last communication between Insurer and Dr. Jamrich's office prior to November 4, 2008 was an October 14, 2008 letter from Ms. Orozco asking Dr. Jamrich to address the connection between Claimant's recurrent herniation and her August 21, 2008 work activities. None of Dr. Jamrich's medical records prior to October 14, 2008 addressed Ms. Orozco's concern and Dr. Jamrich did not respond to Ms. Orozco's concerns in the November 4, 2008 written request for authorization. Because the request for prior authorization did not comply with the requirements of WCRP 16-9(E), Claimant has failed to establish that Respondents violated a Rule. Therefore, Claimant's request for penalties is denied.

Disfigurement

11. Section 8-42-108, C.R.S. provides that a claimant may obtain additional compensation if she is seriously disfigured as the result of an industrial injury. As found, as a result of Claimant's November 12, 2008 surgery she incurred a scar on her lower back that is approximately six inches long and one-eighth inch wide. However, because Claimant's scarring from her November 12, 2008 surgery was not related to her August 21, 2008 employment activities, she is not entitled to a disfigurement award.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's request for Workers' Compensation benefits is denied and dismissed. It is therefore unnecessary to address her claims for medical and TTD benefits or to determine her AWW.

2. Claimant's request for penalties is denied.

3. Claimant's request for a disfigurement award is denied.

4. Any issues not resolved in this Order are reserved for future determination.

DATED: October 19, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-784-465

ISSUES

The issues for determination are compensability, medical benefits, temporary total disability benefits from January 6, 2009, to March 23, 2009, and responsibility for the termination of Claimant's employment.

FINDINGS OF FACT

1. On January 6, 2009, shortly before 10:44 a.m., Claimant was found on the floor of Employer's property room
2. Claimant testified that when she reported to work at 7:45 a.m. on January 6, 2009, she noticed a distracting odor at her work station at the front window. Claimant testified that she went to get personal effects from the property room. Claimant testified that when she opened the door to the property room there was an overwhelming smell. Claimant testified that she picked up two envelopes, turned, and fainted.
3. Bell was walking past the property room the morning of January 6, 2009, when he noticed the door to the room was open and Claimant was lying on the floor. He contacted Montano, a paramedic, who was nearby. He also contacted another to call 9-1-1. Bell testified that he did not notice any unusual odors.
4. Montano went into the property room. Claimant was on the floor lying on her abdomen. She was not responsive. Montano checked and found Claimant was breathing, had a pulse, and had no injuries. Claimant had gloves on. There were no envelopes or effects on the floor. Claimant began coughing. Claimant was moved into a seated position on the floor. Paramedics arrived.
5. Montano testified that she did not notice any unusual odors in the property room. She also testified that she had been on her desk near the property room that morning and had not smelled any odors.
6. Paramedics from Denver Health arrived at the scene and contacted Claimant at 10:47 a.m. Claimant reported to them that she felt dizzy prior to passing out. There is no record in their report that Claimant reported an odor or that they noticed an odor. The paramedics transported Claimant to Denver Health for treatment.
7. Claimant reported a strong odor prior to her fainting to her care providers at Denver Health and to the providers she has seen subsequently.
8. Claimant has a prior history of congestive heart failure. Claimant reported dizziness to her health care providers on November 11 and December 18, 2008.
9. Dr. Cervantes, Dr. Bacher, and Dr. Peterson, who provided care to Claimant at Denver Health, report that Claimant's faint on January 6, 2009, was most likely a vasovagal response to an overwhelming order she encountered while at work. Dr. Hutcherson testified that while an odor did not directly cause Claimant to faint, an odor could have triggered gagging, which triggered a vasovagal reaction that resulted in fainting.
10. Claimant's testimony that there was a strong odor in the property room is not credible. It is found that Claimant's faint on January 6, 2009, was not the result of an overwhelming or strong odor or any other exposure at work.

CONCLUSIONS OF LAW

The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a rea-

sonable cost to the employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a workers' compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979). The facts in the workers' compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S.

The Judge's factual findings concern only evidence that is dispositive of the issues involved: the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo.App. 2000).

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 27 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

An injury is compensable if it "arises out of and in the course of employment", Section 8-41-301(1)(b), C.R.S; *Price v. Industrial Claim Appeals Office,* 919 P.2d 207 (Colo. 1996). An injury arises "out of" employment when the origins of the injury are sufficiently related to the conditions and circumstances under which the employee usually performs his job to be considered part of the employee's services to the employer. *General Cable Company v. Industrial Claim Appeals Office*, 878 P.2d 118 (Colo.App. 1994).

It is more probable than not that Claimant's fainting episode on January 6, 2009, was caused by Claimant's non-work related health conditions and did not arise out of her employment. Claimant has failed to establish by a preponderance of the evidence that her injury arose out of her employment. The claim is not compensable.

ORDER

It is therefore ordered that the claim is denied and dismissed.

DATED: *October 19, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-727-504

ISSUES

The issues determined herein are compensability, average weekly wage, authorized medical benefits, temporary disability benefits and determination of liability under the statutory employer provisions of the Workers' Compensation Act.

Based on the evidence, Respondents' RAH and AHI's Motion for Directed Verdict was granted and they were dismissed as parties to this claim on the date of hearing.

FINDINGS OF FACT

1. Respondent-Employer GC hired claimant as a laborer. His duties consisted primarily of pouring of concrete for foundations of new residential construction. This was medium to heavy work, which included lifting over 25 pounds, as well as bending, and stooping. He was paid $10 per hour and worked 50 hours a week. His employer did not pay overtime.
2. On April 2, 2007, Claimant was working at the Trails End subdivision in Monument, Colorado. He was walking on the completed foundation removing forms when he slipped on a piece of loose wood and fell into the basement approximately 8 to10 feet below, injuring his back.
3. His employer GC took him to Emergicare for treatment the same day. He was referred for physical therapy and given a prescription for medications. He was also given work restrictions. He returned to Emergicare on April 9 and April 23, 2007 continuing to complain of pain in his back. He was given work restrictions on both occasions. He had a final appointment with Emergicare on May 8, 2007. He was referred to Dr. Mock for chiropractic care. He was again given work restrictions. He was unable to obtain additional treatment due to the fact that the Respondent-Employer GC failed to pay Emergicare for the services rendered.
4. Claimant was not able to return for treatment until approximately 16 months later when Respondent-Insurer PA referred him to Dr. Miguel Castrejon. His first appointment with Dr. Castrejon occurred August 4, 2008. He was given x-rays of the lumber spine and referred for chiropractic treatment as well as given prescriptions for medications. He was given work restrictions of no lifting over 25 pounds and limited bending/stooping activities. He returned to Dr. Castrejon on September 4, 2008 reporting improvement. He was given a referral for additional physical therapy as well as continued work restrictions. His next appointment with Dr. Castrejon occurred on November 10, 2008. He was placed in maximum medical improvement, provided a permanent impairment rating and released with no permanent restrictions. He was then discharged from treatment.
5. After the date of injury, Claimant was unable to return to his job with Respondent-Employer GC due to his symptoms and physical restrictions. He did obtain subsequent employment as a banquet worker for a short time but was unable to continue this job because of the discomfort in his back. There is some evidence that Claimant may have worked in September 2008 for a period of time folding papers. The ALJ finds insufficient credible evidence in the record to support Claimant’s having returned to regular or modified employment pursuant to statute. Additionally, there is insufficient credible evidence to de-

termine if Claimant earned any wages during this period or was just helping a friend. He did not return to regular work again until after Dr. Castrejon placed him at maximum medical improvement.

6. Claimant's injury took place in the Trails End subdivision in Monument, Colorado. RAH was the general contractor for the entire subdivision.

7. During the last half of 2006 and all of 2007, RAH subcontracted all of the foundation work in the Trails End subdivision to FI. FI in turn subcontracted part of this work to GC.

8. While there is some conflicting evidence the ALJ finds that the credible evidence of record, including the testimony of the Claimant, establishes that it is more likely than not that Claimant's injury occurred on a job that was subcontracted by Respondent-Employer FI to subcontractor and Respondent-Employer GC.

9. The credible evidence establishes that it is more likely than not that Respondent-Employer GC did not have Workers' Compensation insurance covering the Claimant at the time of the injury.

10. Claimant has established by credible evidence that it is more likely than not that Respondent-Employer FI is the most immediate insured contractor with subcontractor Respondent-Employer GC and, thus, Respondent-Employer FI is the statutory employer of Claimant and is responsible for all consequences arising from Claimant's injury for which the Workers' Compensation Act of Colorado provides a remedy.

11. Claimant has established by credible evidence that it is more likely than not that his average weekly wage is $500.00.

12. Claimant's primary duties consisted of constructing foundations. This was heavy work requiring lifting of more than 25 pounds as well as bending and stooping. Claimant was unable to return to this work due to his symptoms and physical restrictions after the injury. The medical records establish that Claimant had restrictions preventing him from lifting over 25 pounds or bending and stooping from the date of injury until he was placed at maximum medical improvement on November 10, 2008. Claimant has established by credible evidence that it is more likely than not that he was disabled from performing his regular duties during that period of time and is entitled to temporary total disability benefits with the exception of the period of time Claimant was briefly employed between April 10, 2007 and May 27, 2007. During this time Claimant worked as a banquet worker for 32.5 hours, earning $317.58. The ALJ finds that this attempt to return to work did not constitute regular or modified employment. Claimant is entitled to temporary partial disability benefits for this period.

CONCLUSIONS OF LAW

1. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett,* 33 P.3d 1230 (Colo.App. 2001). Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a Workers' Compensation case are not interpreted liberally in favor of either Claimant or Respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after

considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979). Claimant satisfied his burden of proof by establishing by a preponderance of the evidence that he sustained a compensable injury to his low back region on April 2, 2007, while working for Respondent-Employer GC. Claimant's injury arose out of and occurred in the course of his employment with the Respondent-Employer GC.

2. C.R.S. 8-41-401(1)(a) creates a statutory employment relationship where a company contracts out part or all of its work to any subcontractor. Such a company is liable to pay compensation for injuries to employees of subcontractors. "The purpose of the statute is to prevent employers from "avoiding responsibility under the Workers' Compensation act by subcontracting out their regular business to uninsured independent contractors." *Finlay v. Storage Technology Corporation,* 764 P.2d 62 (Colo. 1988). Respondent-Employer FI is a statutory employer in this claim and therefore liable for benefits associated with the April 2, 2007, injury. Because FI was an intervening subcontractor with Workers' Compensation insurance, Respondents' RAH and AHI are not liable for this claim.

3. Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused Claimant to leave work, and Claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. *PDM Molding, Inc. v. Stanberg,* 898 P.2d 542 (Colo. 1995). Claimant satisfied his burden of proof by showing by a preponderance of the evidence that he is entitled to TTD benefits flowing from the April 2, 2007 injury beginning April 2, 2007 and continuing until he was placed at MMI on November 10, 2008, with the exception of the period between April 10, 2007 and May 27, 2007. The ALJ concludes that Claimant’s attempt to return to the work force did not constitute regular or modified employment such that it acted to terminate Claimant’s temporary benefits.

4. Under Section 8-42-1 06, C.R.S., "in case of temporary partial disability, the employee shall receive sixty-six and two-thirds percent of the difference between the employee's average weekly wage at the time of the injury and said employee's average weekly wage during the continuance of the temporary partial disability. " Claimant satisfied his burden of proof by showing by a preponderance of the evidence that he is entitled to TPD benefits during the period between April 10, 2007 and May 27, 2007.

5. The objective of wage calculation for the average weekly wage is to reach a fair approximation of the Claimant's actual wage loss and diminished earning capacity. *Campbell v. IBM Corp.,* 867 P.2d 77 (Colo. App. 1993). The Administrative Law Judge under normal circumstances has broad discretion in calculating the employee's average weekly wage according to the facts of the case to fairly determine the Claimant's weekly wage. *Williams Bros. v. Grimm,* 88 Colo. 416, 297 P. 1003 (1931). Claimant has proven by a preponderance of the evidence that his AWW is $500 a week.

6. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission,* 759 P.2d 705 (Colo. 1988). Claimant has proven by a preponderance of the evidence that he is entitled to medical benefits to cure and/or relieve any low back injury in this claim.

ORDER

It is therefore ordered that:

1. Respondent-Insurer PA shall pay for all reasonable and necessary medical care to cure and/or relieve any low back injury in this claim.
2. Respondent-Insurer PA shall pay Claimant temporary total disability benefits for the period April 2, 2007 through November 10, 2008 based upon an average weekly wage of $500.00 per week, except as stated below.
3. Respondent-Insurer shall pay Claimant temporary partial disability benefits for the period April 10, 2007 and May 27, 2007 based upon Claimant's wages received during that time of $317.58.
4. Respondents shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.
5. Any and all issues not determined herein are reserved for future decision.
6. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
7. All matters not determined herein are reserved for future determination.

DATE: October 20, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-785-763

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. Claimant alleged a specific, traumatic injury occurring on June 1, 2008. At the time of the injury, Claimant was employed by the Employer herein as a banquet captain for approximately ten months.

2. According to Claimant, at the time of the alleged injury he was moving a banquet table at the Denver Convention Center when, upon lifting the table, he twisted and felt a "pop" in his backside. Apparently, these were heavy tables with blocks on them weighing approximately 100 to 200 pounds.

3. After the incident, Claimant continued to work for the rest of the day, but reported the injury to his supervisor. That night he continued to experience pain in his leg and had problems sleeping.

4. On June 4, 2008, Sara A. Harvey, M.D., treated the Claimant for a lumbar strain. He returned to work on restricted lifting duty. The ALJ finds that Claimant sustained a minor, temporary exacerbation of his underlying osteoarthritis that Dr. Harvey diagnosed as a lumbar strain and a groin strain.

5. On June 12, 2008, Jonathan H. Bloch, D.O., saw the Claimant. Dr. Bloch also diagnosed a lumbar strain. Dr. Bloch ordered X-rays, and he additionally diagnosed Claimant with hip enthesopathy from significant degenerative arthritis. Dr. Bloch noted that Claimant had end-stage osteoarthritis with bone-on-bone arthritis in the superior hip joint. On July 18, 2008, Dr. Bloch released Claimant from his care for the lumbar strain, declaring the Claimant to be at maximum medical improvement (MMI) without impairment from the lumbar strain. Dr. Bloch indicated that there was "possible malingering." Dr. Bloch released the Claimant to return to work at full duty as of July 18, 2008.

6. Claimant underwent physical therapy from June 12, 2008 through July 9, 2008 with little to no improvement.

7. On September 23, 2008, Claimant was referred to Scott G. Resig, M.D., at Denver-Vail Orthopedics, P.C., for an individual consultation. Claimant continued to complain of groin pain radiating to his lower back and thighs. Dr. Resig recommended steroid injections to the hip, which gave Claimant only short-term relief.

8. During a follow-up visit on October 21, 2008, Dr. Resig recommended a total hip replacement as the solution to eliminate Claimant's pain completely.

9. Kirk Holmboe, D.O., assessed Claimant from October through December 2008. Dr. Holmboe noted Claimant's increase in pain and increased difficulty maneuvering at work. Dr. Holmboe prescribed pain medication as temporary relief to manage Claimant's pain in his hip.

10. Claimant seeks medical benefits for total hip replacement surgery.

11. Claimant underwent an Independent Medical Examination (IME) by John Burris, M.D. on December 16, 2008. Dr. Burris concluded that Claimant's need for a hip replacement was not related to the worker's compensation injury. Specifically, Dr. Burris determined that the mechanism of the work-related injury was minor and did not cause the osteoarthritis in Claimant's left hip. Dr. Burris' testimony is credible and consistent with the record and the findings of the other physicians.

12. James P. Lindberg, M.D. of Advanced Orthopedic and Sports Medicine Specialists was also consulted as to his opinion on the relationship between Claimant's work related injury and the prognosis for a hip replacement. Dr. Lindberg found that the mechanisms of injury did not cause the need for a total hip replacement. Rather, the cause of the need for a total hip replacement, according to Dr. Lindberg, is significant osteoarthritis in his left hip. Dr. Lindberg concluded that the injury is consistent with ac-

tivities of daily living and not with a significant worker's compensation injury. Accordingly, the Claimant was as at MMI. Dr. Lindberg's testimony is credible and consistent with the record and the findings from the other physicians.

13. Claimant's medical treatment, related to the alleged hip injury from June 1, 2008 through the present has been paid in full by the Respondents.

14. Claimant denies any sort of hip pain prior to the June 1, 2008 injury at work. The physicians in this case, Dr. Bloch, Dr. Lindberg, Dr. Burris, Dr. Holmboe, and Dr. Resig diagnosed Claimant with end-stage hip osteoarthritis. Specifically, Dr. Lindberg and Dr. Burris were of the opinion that Claimant's type of condition has the tendency to wax and wane over time. It is, therefore, difficult to find Claimant's testimony credible. While a total hip replacement is likely reasonable and necessary to relieve Claimant's hip pain, it is not secondary to the work-related injury.

15. Claimant has proven, by preponderant evidence that he sustained a compensable lumbar and groin strain on June 1, 2008, arising out of the course and scope of his employment for the Employer herein. He reached MMI for these strains on July 18, 2008. Claimant has failed to prove, by a preponderance of the evidence, that he sustained a compensable aggravation of his pre-existing hip osteoarthritis. Claimant failed to show that his need for a total hip replacement surgery arose out of the course and scope of his employment for the Employer when he was lifting a banquet table.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002). The same principles concerning credibility determinations that apply to lay witnesses apply to expert witnesses as well. *See Burnham v. Grant,* 24 Colo. App. 131, 134 P. 254 (1913). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions (this includes whether or not the expert opinions are adequately founded upon appropriate research); the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). The fact finder should consider an expert witness' special knowledge, training, experience or research (or lack thereof). *See Young v. Burke,* 139 Colo. 305, 338 P. 2d 284 (1959). As found, the Claimant's testimony lacked credibility because it conflicted with the practical application of the numerous medical consults assessing Claimant's hip injury. Although Claimant claimed that he had never experienced hip pain prior to the June 1, 2008 injury, Respondents presented undisputed evidence

that Claimant has end-stage osteoarthritis in his hip. As also found, the testimony of Dr. Lindberg and Dr. Burris was credible and persuasive. Dr. Lindberg provided credible testimony that although the June 1, 2008 injury may have temporarily exacerbated Claimant's pre-existing osteoarthritis condition, the condition is the cause for the needed surgery, and the osteoarthritis was not caused by Claimant's work. Essentially, the injury at the Employer was no different than any daily activity in which Claimant may have involved himself. Dr. Lindberg and Dr. Burris were of the opinion that arthritis pain, like Claimant's, waxes and wanes over time, and a hip replacement would be eventually inevitable given Claimant's pre-existing, end-stage condition.

b. § 8-41-301 (1), C.R.S. (2009), provides a right to workers' compensation benefits for injuries occurring within the course and scope of employment. As found, the Claimant sustained lumbar and groin strains as a result of the work-related moving incident of June 1, 2008 for which he received medical care and treatment. As further found, the Claimant reached MMI with no impairment from the lumbar and groin strains on July 18, 2008.

c. To be a compensable benefit, medical care and treatment must be causally related to an industrial injury or occupational disease. *Dependable Cleaners v. Vasquez,* 883 P. 2d 583 (Colo. App. 1994). As found, Claimant's claim for a hip replacement is not causally related to the work injury on June 1, 2008. Also, medical treatment must be reasonably necessary to cure and relieve the effects of the industrial occupational disease. § 8-42-101 (1) (a), C.R.S. (2009). *Morey Mercantile v. Flynt,* 97 Colo. 163, 47 P. 2d 864 (1935); *Sims v. Industrial Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990). As found, although a total hip replacement is reasonable and necessary to relieve Claimant's hip pain, it is not secondary to the work-related injury.

d. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. (2009). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant has proven a compensable low back and groin strain as a result of the June 1, 2008, moving incident. He reached MMI without impairment for these conditions on July 18, 2008. He failed to prove a compensable aggravation of his underlying osteoarthritic disease in order to establish a causal, work-related link to Claimant's need for a total hip replacement.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents shall pay the costs of authorized medical care and treatment for the Claimant's low back and groin strains through July 18, 2008, in accordance with the Division of Workers' Compensation Medical Fee Schedule.

B. Claimant did not suffer a compensable aggravation of his pre-existing osteoarthritic condition.

C. Any and all claims for workers' compensation benefits pertaining to total left hip replacement surgery, are hereby denied and dismissed.

D. Any and all issues not determined herein are reserved for future decision.

DATED this 21 day of October 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-687-922

ISSUES

The issues for determination are compensability, average weekly wage, temporary total disability benefits, and responsibility for termination.

FINDINGS OF FACT

1. Claimant worked for Employer for six or seven years as a cashier and one or two years as an assistant manager. Her daily duties included using the cash register, counting cash, and stocking product. She used a broom and scrubbed with her hands. Her work activities varied throughout the workday. Claimant did not perform any hand-intensive activities outside of work.
2. Claimant noticed pain in her upper extremities in April 2006. Claimant suffers from carpal tunnel syndrome (CTS). Surgery has been recommended.
3. Christopher S. Wilson, M.D., examined Claimant on June 16, 2006. He stated that Claimant's CTS was "caused by her hand activities at work."
4. Craig Davis, M.D., examined Claimant on July 25, 2006. He noted that Claimant's job involved full-time cashiering, counting money, and stocking. Dr. Davis stated that, "I think it is reasonable to assume that this patient's carpel tunnel syndrome is due to her work activities." George Kohake, M.D., agreed with Dr. Davis' opinion.
5. Sander Orent, M.D., evaluated Claimant in August 2006. Dr. Orent specializes in occupational and environmental medicine, as well as internal medicine. He is board certified in both of these fields and is Level II accredited. Dr. Orent reviewed Claimant's performance of her work duties, as seen on surveillance films taken at the convenience store. He also took a detailed history from Claimant about her work activities. From the

history taken from Claimant and from his observation of Claimant's job duties on the surveillance films, Dr. Orent could see no evidence that the Claimant was engaged in activities which have been associated medically or scientifically with the development of carpal tunnel syndrome. Dr. Orent did not agree with Dr. Davis that there was "heavy use of hands" by Claimant in the performance of her job duties. Dr. Orent classifies "heavy use of the hands" as activities where workers bone meat or fish with "lots of torque or forceful extension." Claimant gave Dr. Orent a history that she experienced her symptoms regardless of her work activities. This does not show good correlation between the work activities of Claimant and her symptoms. Dr. Orent keeps current on the medical literature with regard to the causality of carpal tunnel syndrome. Over the course of the last few years, carpal tunnel syndrome has only rarely been associated with occupational job duties. The vast majority of carpal tunnel syndrome cases are not occupational. A table issued by the Division of Workers' Compensation that is an Exhibit to the Medical Treatment Guidelines discusses the risk factors associated with carpal tunnel syndrome. The activities described there are not present in Claimant's job. Dr. Orent found a deformity in Claimant's thumb and swelling in the joints. This would be seen in an inflammatory process that is more likely to cause carpal tunnel syndrome than occupational activities. Dr. Orent stated that Claimant did not have an injurious exposure capable of causing carpal tunnel syndrome in her job activities.

6. Neither Dr. Wilson, Dr. Davis, nor Dr. Kohake systematically addressed causality. Their opinions are not persuasive. Dr. Orent's' report and testimony regarding causation of Claimant's CTS was thorough and complete. His opinion is credible and persuasive.

7. Claimant's job activities for Employer did not cause her CTS.

CONCLUSIONS OF LAW

To prove a compensable injury, a claimant has the burden to prove by a preponderance of evidence that her injury arose out of and in the course of her employment. Section 8-41-301(1)(c), C.R.S.; *Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo.App. 2000). Proof by a preponderance of the evidence requires the proponent to establish that the existence of a "contested fact is more probable than its nonexistence." *Page v. Clark*, 197 Colo. 306, 592 P.2d 792, 800 (1979).

An occupational disease is "a disease which results directly from the employment or conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard which the worker would have been equally exposed outside of the employment." Section 8-40-201(14), C.R.S. A claimant seeking benefits for an occupational disease must first establish the existence of the disease and that it was directly and proximately caused by the claimant's employment or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claims,* 989 P.2d 251, (Colo.App. 1999); *Cowin & Co. v. Medina,* 860 P. 2d 535 (Colo.App. 1992).

The opinions of Dr. Orent are credible and persuasive. Claimant's job duties did not involve activities that were sufficient to cause her CTS. The claim is not compensable.

The issues of average weekly wage, responsibility for termination of employment, and temporary disability benefits are not reached.

ORDER

It is therefore ordered that the claim is denied and dismissed.

DATED: *October 20, 2009*

Bruce C. Friend, Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-710-008

ISSUES

The issues to be determined by this decision concern Claimant's application to overcome the Division Independent Medical Examination (DIME) of Darrel K. Quick, M.D.; degree of permanent medical impairment; and, bodily disfigurement. The Claimant's burden of proof is "clear and convincing evidence.

At the conclusion of the Claimant's case-in-chief, Respondent moved for judgment on the evidence in Claimant's case on the proposition that Claimant's evidence could not get any better as of that time. The motion was granted.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. Claimant was seriously injured in a work-related accident on December 28, 2006. According to the October 22, 2008, report of Susan E. Ladley-O'Brien, M.D., Claimant's authorized treating physician (ATP), the Claimant's injuries included: (i) pelvic fractures with bilateral sacral-iliac joint diastasis status post open reduction and internal fixation; (ii) Bladder rupture status post cystorrhaphy without current urinary symptoms; (iii) Status post sigmoid avulsion from the rectum with loop ileostomy and subsequent ileostomy takedown; (iv) Left obturator nerve injury with no current strength deficits on physical examination; (v)Status post left testicular infarct with atrophy and documented oligospermia; and, (vi)Ventral abdominal hernia status post fixation with no current defect; (vii) Abdominal and pelvic scars.

2. Dr. Ladley-O'Brien found that Claimant reached maximum medical improvement (MMI) on October 22, 2008, and provided the following impairment ratings: (i) 12% impairment for range of motion loss in the lumbar spine; (ii).10% impairment for the testicular infarct and atrophy; (iii) 8 % impairment for bilateral sacroiliac joint diastasis; (iv) 5% for pelvic fracture with displacement of bilateral pelvic rami; (v) 10% scheduled impairment for loss of left hip range of motion; and, (vi) 2% scheduled impairment for loss of right hip range of motion. Dr. Ladley-O'Brien's total whole person impairment rating was 36%.

3. Dr. Ladley O'Brien declined to provide any impairment rating for urinary problems.

4. Respondent filed a Final Admission of Liability (FAL) consistent with Dr. Ladley-O'Brien's determinations on November 20, 2008.

5. Dr. Quick performed a DIME on April 7, 2009. Dr. Quick agreed that Claimant reached MMI on October 22, 2008. He provided the following diagnoses: (i) Pelvic fractures with bilateral SI joint diastasis; (ii) Fracture of the bilateral inferior and superior pubic rami, status post ORIF; (iii) Bladder rupture without current symptoms; (iv) Total sigmoid colon avulsion, current mild bowel irregularities; (v) Left obturator nerve palsy, resolved; (vi) Left testicular incarceration with atrophy and oligospermia; and, (vii) Incarcerated ventral hernia with diastatis recti, requiring surgical repair.

6. Dr. Quick provided the following impairment ratings: (i) 10% impairment of the lumbar spine due to specific disorders as calculated in reference to Section 3.4 on page 101 of the *AMA Guides to Evaluation of Permanent Impairment*, 3rd Ed., Rev; (ii)9% impairment for loss of lumbar range of motion; (iii) 6% impairment for testicular injuries pursuant Sections 11.4 and 11.4C of the AMA Guides including an increase by 50% due to the fact that Claimant is less that forty years old; (iv) 5% for bilateral rami fractures pursuant Section 3.4, Category 3.b of the AMA Guides. (v) 2% scheduled impairment of the right hip; and, (vi) 14% scheduled impairment of the left hip. Dr. Quick's overall medical impairment rating was 32% whole person; 2% of the right lower extremity (RLE); and, 10% of the left lower extremity (LLE).

7. Dr. Quick was of the opinion that Claimant's urinary function was normal and the urinary stream was normal and without urgency, incontinence, or dysuria.

8. Dr. Quick's DIME report shows that he considered all appropriate factors, arrived at diagnoses similar to Dr. Ladley-O'Brien's diagnosis, and correctly applied the provisions of the *AMA Guides to the Evluation of Permanent Impairment,* 3rd Ed., Rev., and the Director's Impairment Rating tips to arrive at his impairment rating.

9. The Employer filed a subsequent Final Admission of Liability consistent with Dr. Quick's determinations on May 5, 2009, admitting for 32% whole person permanent medical impairment; and, for 2% RLE and 10% LLE permanent scheduled impairment.

10. According to the Claimant, he has current bladder problems and he sometimes has to urinate up to six or seven times per day with pain in the lower bladder area and in his penis. His urine is sometimes orange in color although he stated that he usually drinks a liter or more of water during the workday. The Claimant's testimony in this regard is neither supported by his ATP, or by the DIME physician. Consequently, the ALJ finds that Claimant has failed to prove that this situation is causally related to his admitted, compensable injury of December 28, 2006.

11. Claimant indicated that Dr. Quick asked him if he had any bladder problems and Claimant replied that his bladder was fine. Claimant explained that he did not want to discuss these problems with Dr. Quick because he feared that he might lose his job if his impairment rating was too high. Under the circumstances, this testimony at hearing makes no sense. The ALJ finds that Claimant's statement to Dr. Quick is more reliable.

12. Claimant offered no expert opinions from any doctors that tended to show that Dr. Quick's impairment rating was incorrect. The medical opinions of the DIME physician and the ATP are undisputed by any other medical opinion. Indeed, Claimant failed to prove that it is highly likely, unmistakable and free from serious and substantial doubt that Dr. Quick's opinions on causally related conditions (to the work injury); MMI date, and degree of permanent medical impairment were erroneous. Claimant failed to overcome Dr. Quick's DIME opinions by clear and convincing evidence.

13. Claimant manifested a 14-inch long, 1 to 1 ½ inch wide keloid-like scar, vertically along the mid-line of his abdomen that begins below his beltine and proceeds upward, snakes around his navel, and ends near his sternum; he also manifests a 4-inch long, 2-inch wide keloid-like scar above his right hip; a 3—inch long, 1 ¼ inch wide indented bump, diagonally above the right hip; and, on the left side of his abdomen, Claimant has a 3 inch by 2 inch scar that is indented between ¾ inch and 1 inch. These scars constitute serious, permanent disfigurement of Claimant's body that is normally exposed to public view.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

a. At the close of Claimant's evidence on the issue of permanent partial disability benefits, the Employer moved to dismiss, based on Colorado Rules of Civil Procedure [C.R.C.P.], Rule 41(b) (1), which provides in part:

> "After the plaintiff, in an action tried by the court without a jury, has completed the presentation of his evidence, the defendant, without waiving his right to offer evidence in the event the motion is not granted, may move for a dismissal on the ground that upon the facts and the law the plaintiff has shown no right to relief."

Rule 41(b)(1), provides that, after a plaintiff in a civil action *tried without a jury* has completed the presentation of his evidence, the defendant may move for a dismissal on the grounds that the plaintiff has failed to present a prima facie case for relief. In determining whether to grant a motion to dismiss or for directed verdict, the court is not required to view the evidence in the light most favorable to the plaintiff, as argued by a claimant. *Rowe v. Bowers*, 160 Colo. 379, 417 P.2d 503 (Colo. 1966)*; Blea v. Deluxe/ Current, Inc.*, W.C. No. 3-940-062 [Industrial Claim Appeals Office (ICAO), June 18, 1997] (applying these principles to workers' compensation proceedings). Neither is the court required to "indulge in every reasonable inference that can be legitimately drawn from the evidence" in favor of the Claimant. Rather, the test is whether judgment for the respondents is justified on the claimant's evidence. *Amer. National Bank v. First National Bank*, 28 Colo. App. 486, 476 P.2d 304 (Colo. App. 1970); *Bruce v. Moffat County Youth Care Center*, W. C. No. 4-311-203 (ICAO, March 23, 1998). The question of whether the Claimant carried this burden was one of fact for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

b. As found, the medical opinions of the ATP and the DIME physician are essentially un-contradicted by any other medical evidence. *See, Annotation, Comment: Credibility of Witness Giving Un-contradicted Testimony as Matter for Court or Jury,* 62 ALR 2d 1179, maintaining that the fact finder is not free to disregard un-contradicted testimony. Therefore, the ALJ should not disregard them.

c. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions; the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). As found, the Claimant's testimony about fearing to disclose his urinary problems to the DIME physician because he feared that he would be fired is inconsistent with reason and common sense in light of the seriousness of his injuries and in light of the fact that his ATP had already given him the fairly high permanent impairment rating of 36% whole person. Therefore, the ALJ does not find the Claimant's testimony credible with respect to the causal relatedness of the urinary problems.

d. The D IME physician's determinations of MMI and permanent medical impairment are binding on the parties unless overcome by clear and convincing evidence. § 8-42-107(8)(b)(III), C.R.S. (2009). *Montoya v. Industrial Claim Appeals Office*, 203 P.3d 620 (Colo. App. 2008). The party seeking to overcome a DIME physician's opinions bears the burden of proof by clear and convincing evidence. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000). It is well established

that the DIME physician's determination of MMI is binding unless overcome by "clear and convincing evidence." *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995); Section 8-42-107(b)-(c), C.R.S. (2009). Also, a DIME physician's conclusion that an injured worker's medical problems were components of the injured worker's overall impairment constitutes a part of the diagnostic assessment that comprises the DIME process and ,as such the conclusion must be given presumptive effect and can only be overcome by clear and convincing evidence. *Qual-Med, Inc. v. Indus. Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998). "Clear and convincing evidence" is evidence, which is stronger than preponderance, is unmistakable, makes a fact or facts highly probable or the converse, and is free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert, supra.* In other words, a DIME physician's finding may not be overcome unless the evidence establishes that it is "highly probable" that the DIME physician's opinion is incorrect. *Postelwait v. Midwest Barricade,* 905 P. 2d 21 (Colo. App. 1995). The question of whether the DIME physician has placed a claimant at MMI or not, and whether that determination has been overcome is a factual determination for resolution by the ALJ. *Metro Moving & Storage Co. v. Gussert*, *supra.* As found, the Claimant has failed to overcome the DIME physician's opinions on causal relatedness to the admitted injury; on MMI; and, on the degree of permanent medical impairment of 32% whole person; 2% RLE; and, 10% LLE.

e. The Claimant has sustained a serious permanent disfigurement to areas of his body normally exposed to public view. *See Arkin v. Industrial Commission,* 145 Colo. 463, 358 P. 2d 879 (1961). Respondents should pay the Claimant $2,000 for that disfigurement. § 8-42-108 C.R.S. (2009).

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. The Division Independent Medical Examination opinion of Darrel K. Quick, M.D., on the work relatedness of Claimant's medical conditions; on the date of maximum medical improvement; and, on the degree of permanent medical impairment, both whole person and scheduled are affirmed.

B. The latest Final Admission of Liability, dated March 18, 2008, is hereby affirmed and adopted and the Order of the ALJ, as if fully restated herein.

C. Respondent shall continue to pay the costs of authorized, causally related and reasonably necessary post-maximum medical improvement maintenance medical benefits, subject to the Division of Workers' Compensation Medical Fee Schedule.

D. For and account of Claimant's bodily disfigurement, Respondent shall pay the Claimant $2,000, in one lump sum, in addition to all other benefits due and payable.

DATED this 21 day of October 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-746-176

ISSUES

1. Authorized medical benefits;
2. Temporary total disability from December 28, 2007 to February 15, 2008 and from November 10, 2008 to January 12, 2009;
3. Relatedness;
4. Consolidation of Workers' Compensation Nos. 4-746-176 and 4-796-319;
5. Compensability as to WC No. 4-796-319; and
6. Attorney's fees pursuant to C.R.S. § 8-41-301(14).

FINDINGS OF FACT

1. Workers' Compensation Nos. 4-746-176 and 4-796-319 are consolidated for hearing purposes.

2. According to Judge Jones' Order of December 16, 2008, Claimant aggravated her pre-existing condition on December 28, 2007. Judge Jones also found that on January 1, 2008, Claimant was taken by ambulance to Rose Medical Center Emergency Department for acute low back pain and seen by Dr. Shogan in the emergency room on January 2, 2008.

3. Following the December 28, 2007 work related injury, Claimant reported the injury to her supervisor, Ms. Ehlen. At that time, Ms. Ehlen did not refer Claimant to a medical provider. Ms. Ehlen testified that through meetings, Claimant knew to go to the emergency department or employee health nurse or occupational health clinics. Respondents' exhibit L page 63 sets forth the procedure an employee shall follow in the event of a work related injury. Policy 2 states that if emergency medical care is needed, the employee is to report to "any HealthONE emergency facility". Ms. Ehlen and the claims adjuster, Monica Westlund, both testified that HealthOne Rose Medical Center is a HealthOne emergency medical facility.

4. Claimant was taken by ambulance to HealthOne Rose Medical Center due to excruciating pain and inability to walk on January 1, 2008. Claimant was admitted into

the emergency room and later admitted to the hospital where Dr. Shogan recommended surgery that was performed on January 3, 2008. The January 2, 2008 medical report from Dr. Shogan at Rose Medical Center sets forth: "Since that time, the pain has become progressively more severe. She has been experiencing excruciating pain radiating in a radicular fashion to her right leg. The patient was seen in the Rose Medical Center Emergency Room and admitted for further evaluation and treatment." Dr. Shogan opined that operative intervention at that time was appropriate. On January 3, 2008, Dr. Shogan performed a "Re-do right-sided L5-S1 semi-hemilaminectomy with disk excision."

5. The emergency room visit on January 1, 2008, the hospitalization on and after January 2, 2008 at HealthOne Rose Medical Center, and Dr. Shogan's surgery were emergency medical treatment. This finding is supported by the medical records documenting Claimant's excruciating pain and narcotic pain medication, Claimant's testimony concerning her pain levels and inability to walk, and Ms. Westlund's notes dated January 2, 2008 wherein she wrote, "Received call from IW who is in-patient at Rose Medical Center. **No recorded statement was obtained as IW was on IV morphine due to level of pain."** (Emphasis added) Respondents are responsible for the expenses incurred at HealthOne Rose Medical Center and Dr. Shogan for the surgery performed on January 3, 2008 as a result of the compensable December 28, 2007 injury.

6. Employer's workers' compensation policy, Exhibit L page 64 sets forth under paragraph 5: "If additional care is required, employees will be referred by Employee Health Services to a clinic within the HealthONE Occupational Health System or other designated provider." Respondent failed to show that Employee Health Services referred Claimant to a designated provider before or after Claimant's January 3, 2008 surgery. Claimant's supervisor did not refer Claimant to a designated provider when Claimant reported the injury or after the surgery. Ms. Westlund's testimony that she told Claimant on January 2, 2008 while Claimant was in Rose Medical Center and on IV morphine pump that Dr. Shogan was not authorized and Claimant needed to go through a HealthOne clinic to get a referral is not persuasive. Ms. Westlund's testimony is not support by her January 2, 2008 notes of that conversation. Ms. Westlund's notes of that day are detailed and do not contain any statement that she informed Claimant that Dr. Shogan and the surgery are not authorized and to seek treatment at a HealthOne clinic.

7. Respondent failed to designate a medical provider in the first instance and the right to select a provider passed to Claimant. Claimant chose Dr. Shogan. Therefore, Dr. Shogan and his referrals are authorized. Respondents are responsible for the expenses incurred for treatment by Dr. Shogan and his referrals for the December 28, 2007 injury.

8. Respondents stipulate that Claimant was unable to work as a result of the back injury from December 28, 2007 through February 15, 2008. Claimant returned to work full-duty at the Respondent employer on February 16, 2008.

9. In October 2008, Claimant again experienced low back pain, which she attributed to work activities. Claimant again sought treatment from Dr. Shogan. Claimant

did not report any work-related injury to Jackie Ehlen. Claimant knew to report an injury as she had previously reported her December 28, 2007 injury to Ms. Ehlen. [Respondents' Exhibit, p. 41 and June 12, 2008 Hearing Transcript, p. 59]. Jackie Ehlen credibly testified that the Claimant did not report a work injury in October of 2008. If she had, Jackie Ehlen would have completed the necessary report as she had done for the injury of December 28, 2007.

10. On October 16, 2008, Claimant underwent a pre-operation evaluation with Dr. Jarrell for cosmetic surgery that she planned to have done on October 28, 2008 in Beverly Hills, California. [Respondents' Exhibit, p. 31]. Claimant last worked at Respondent employer on October 26, 2008 as the cosmetic surgery was scheduled for October 28, 2008. [Respondents' Exhibit, p. 44]. During her pre-operation evaluation by Dr. Jarrell, Claimant made no mention of any low back pain. In fact, Claimant told Dr. Jarrell that she was using an elliptical to exercise at least five (5) days per week. [Respondents' Exhibit, p. 44].

11. Claimant also attended with her chiropractor, Dr. Troeger, on October 20, 2008. Claimant reported increased back pain at that time and Dr. Troeger noted a date of injury of October 15, 2008. Dr. Shogan recommended additional physical therapy for the Claimant on October 20, 2008. These recommendations occurred after Claimant saw Dr. Jarrell on October 16, 2008, and before Claimant last worked on October 26, 2008.

12. Claimant was off work from October 27, 2008 until she again went by ambulance to Rose Medical Center on November 24, 2008 for low back pain. Claimant testified she was unable to walk, and that is why she called an ambulance. The ambulance records show that Claimant was reporting increased back pain times three weeks. [Respondents' Exhibit, p. 34]. Claimant was first attended to November 24, 2008 by Dr. Sarnat, who noted the Claimant was reporting increasing back pain times three weeks, which had been caused by an episode of vacuuming at home. [Respondents' Exhibit, p. 8]. Claimant then saw Dr. Thiel at Rose Medical Center on November 25, 2008 and told him that her back pain had been ongoing for three weeks but had increased in the last week. [Respondents' Exhibit, p. 20]. Dr. Shogan noted on December 24, 2008 that Claimant had experienced a marked increase in back pain at the end of November 2008. [Respondents' Exhibit, p. 30].

13. On December 2, 2008, Claimant underwent a third surgery by Dr. Stephen Shogan to her L5-S1 disc. Dr. Shogan again noted the procedure to be a "re-do right-sided L5-S1 disc excision." This was the same disc that Claimant had operated on by Dr. Shogan on December 12, 2006 and on January 3, 2008. [Respondents' Exhibit, p. 18-19].

14. Dr. Hughes reviewed the medical records from Rose Medical Center and Dr. Shogan for the third surgery that occurred on December 2, 2008. Dr. Hughes noted that simply vacuuming could have caused the Claimant's re-herniation considering that bending over had caused the prior re-herniation on December 27, 2008. According to

Dr. Hughes, the Claimant exhibits vulnerability for recurrent disc herniations at that level. She has sustained recurrence of disc herniation two times now since 2006. Dr. Hughes credibly and persuasively opined: "I think the reason for her third surgery was a natural progression of the disk, quite possibly accelerated by vacuuming around three weeks prior to November 24, 2008" [Depo Dr. Hughes p. 18 ll 2-5].

15. Claimant failed to prove by a preponderance of the evidence that she sustained a compensable aggravation of her December 28, 2007 injury in October 2008 while employed by Employer. Claimant had been off work from October 27, 2008 through November 24, 2008 when she went to Rose Medical Center. During this time off work, Claimant had traveled to Beverly Hills, California and undergone cosmetic surgery on October 28, 2008. Claimant's complaints to Rose Medical Center physician, Dr. Sarnat, that she had been pain free and symptom free since the January 3, 2008 surgery until three weeks prior takes her to the time period Claimant was off work.

16. Claimant's request for attorney's fees pursuant to Section 8-43-301(14), C.R.S. alleging Respondents improperly filed a Petition to Review Judge Jones' December 16, 2008 Supplemental Order is denied and dismissed. Judge Jones' Supplemental Order specifically stated that the decision would be final unless a Petition to Review was filed within 20 days. Respondents believed that the Supplemental Order as to compensability would be final if they did not file the petition as instructed to do in the Supplemental Order. Respondents Petition to Review was not filed for wrongful purposes nor was it frivolous.

CONCLUSIONS OF LAW

Whether Dr. Shogan and his referrals were authorized in this matter pursuant to § 8-43-404 (5)(a), C.R.S. 2005.

1. Sec. 8-43-404 (5)(a), C.R.S., gives employers or insurers the right to choose the treating physician in the first instance in order to protect their interests in being apprised of the course of treatment for which they could ultimately be held liable. *Bunch v. ICAO*, 148 P.3d 381 (Colo. App. 2006). If the employee obtains unauthorized medical treatment, the employer or its insurers are not required to pay for it. *Yeck v. ICAO,* 996 P.2d 228 (Colo. App. 1999). The right of selection is not conditioned on an admission of liability. The mere fact that respondents deny liability does not extinguish their interest in being apprised of the course of treatment. *Colorado Fuel and Iron Corp. v. IC*, 269 P.2d 1070 (Colo. 1954). Because respondents are responsible for paying medical bills, they have a legal right to know what is being done. *Dominguez v. Monfort*, WC 3-857-241 (ICAO February 27, 1991).

2. An employer is generally liable only for authorized medical treatment. *Pickett v. Colorado State Hospital*, 513 P.2d 228 (Colo. App. 1973). However, medical services provided in a *bona fide* emergency are an exception to the requirement for

prior authorization. *Sims v. ICAO*, 797 P.2d 777 (Colo. App. 1990). A medical emergency affords an injured worker the right to obtain immediate treatment without undergoing the delay inherent in notifying the employer and obtaining a referral or approval. The emergency room physician does not become an authorized provider. Rather, when the emergency ends the claimant must give notice to the employer of the need for continuing medical service and the employer then has the right to select a physician. *Sims, supra,* at 781. A physician's "authorization" to treat a claimant refers to a physician's status as the healthcare provider legally authorized to treat an injured employee. *Bunch, supra*, at 383. If the employee obtains unauthorized medical treatment, the employer or its insurer is not required to pay for it. *Yeck, supra*.

3. The emergency room visit on January 1, 2008, the hospitalization on and after January 2, 2008 at HealthOne Rose Medical Center, and Dr. Shogan's surgery were emergency medical treatment. This finding is supported by the medical records documenting Claimant's excruciating pain and narcotic pain medication, Claimant's testimony concerning her pain levels and inability to walk, and Ms. Westlund's notes dated January 2, 2008 wherein she wrote, "*Received* call from IW who is in-patient at Rose Medical Center. **No recorded statement was obtained as IW was on IV morphine due to level of pain."** (Emphasis added) Respondents are responsible for the expenses incurred at HealthOne Rose Medical Center and Dr. Shogan for the surgery performed on January 3, 2008 as a result of the compensable December 28, 2007 injury.

4. Employer's workers' compensation policy, Exhibit L page 64 sets forth under paragraph 5: "If additional care is required, employees will be referred by Employee Health Services to a clinic within the HealthONE Occupational Health System or other designated provider." Respondent failed to show that Employee Health Services referred Claimant to a designated provider before or after Claimant's January 3, 2008 surgery. Claimant's supervisor did not refer Claimant to a designated provider when Claimant reported the injury or after the surgery. Ms. Westlund's testimony that she told Claimant on January 2, 2008 while Claimant was in Rose Medical Center and on IV morphine pump that Dr. Shogan was not authorized and Claimant needed to go through a HealthOne clinic to get a referral is not persuasive. Ms. Westlund's testimony is not support by her January 2, 2008 notes of that conversation. Ms. Westlund's notes of that day are detailed and do not contain any statement that she informed Claimant that Dr. Shogan and the surgery are not authorized and to seek treatment at a HealthOne clinic.

5. Respondent failed to designate a medical provider in the first instance and the right to select a provider passed to Claimant. Claimant chose Dr. Shogan. Therefore, Dr. Shogan and his referrals are authorized. Respondents are responsible for the expenses incurred for treatment by Dr. Shogan and his referrals.

Whether Claimant sustained a compensable aggravation of her December 28, 2007 injury in October of 2008 while in the employ of North Suburban Medical Center.

6. The purpose of the Workers' Compensation Act of Colorado (Act) Section 8-40-101, *et seq.* C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Pursuant to Section 8-40-102(1), C.R.S., claimant shoulders the burden of proving by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), C.R.S.; *See City of Boulder v. Streeb,* 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in the favor of the rights of respondents. Section 8-43-201, C.R.S.

7. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The Administrative Law Judge's factual findings concern only evidence that is dispositive of the issues involved. The ALJ is not required to address every piece of evidence that might lead to a conflicting conclusion and can reject contrary evidence as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

8. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice or interests. *See Prudential Insurance Co. v. Cline,* 98 Colo. 275, 57 P.2d 1205 (1936).

9. Claimant contends that her December 28, 2007 work-related injury was aggravated in October of 2008 while in the employ of Employer. However, the evidence shows that Claimant went by ambulance on November 24, 2008 to Rose Medical Center and requested that Dr. Shogan attend to her for increased low back pain. She reported to the ambulance attendant and the emergency room physicians that she had experienced increased back pain for about three weeks. She also told Dr. Shogan per his report of December 24, 2008 that her back pain had become severe at the end of November 2008. She told Dr. Sarnat that she had noticed significantly increased back pain while vacuuming her stairs at home.

10. Although an aggravation of a pre-existing condition is compensable in Colorado under *Denver v. Hansen*, 650 P.2d 139 (Colo. App. 1982), Claimant had been off work from October 27, 2008 until she went by ambulance to Rose Medical Center on November 24, 2008. This is a period of four weeks. Further, Claimant had traveled to Beverly Hills, California and undergone cosmetic surgery on October 28, 2008, which indicates the Claimant's back pain was not severe as of that date. She had passed a pre-operative physical to have that cosmetic surgery. Therefore, to find that Claimant aggravated her pre-existing low back condition in October of 2008 when she had not even worked for four weeks at the point in time she went by ambulance to Rose Medical Center would be contrary to the evidence. Instead, it is more likely that Claimant sus-

tained a separate injury while off work from October 27, 2008 until she went to Rose Medical Center by ambulance on November 24, 2008. As Dr. Hughes pointed out, Claimant's recurrent disc herniations at L5-S1show that Claimant has a vulnerability and a "ubiquitous" condition caused the re-herniation in November 2008. Therefore, Claimant's vacuuming of the stairs at home or some other ubiquitous activity resulted in the disc herniation diagnosed on November 25, 2008, and surgically repaired on December 2, 2008.

Whether Claimant is entitled to attorney's fees for Respondents' improper Petition to Review under Section 8-43-301 (14), C.R.S.

11. Claimant's request for attorney's fees pursuant to Section 8-43-301 (14), C.R.S. for Respondents' improperly filed Petition to Review Judge Jones' Supplemental Order of December 16, 2008 is denied and dismissed. Judge Jones' Supplemental Order of December 16, 2008 noted the following:

> "This decision of the judge is final, unless a Petition to Review this decision is filed within twenty (20) days from the date this decision is served. Section 8-43-301 (2), C.R.S."

12. Although ICAP found the appeal to be interlocutory on April 13, 2009, Respondents' Petition to Review was filed pursuant to Judge Jones' Supplemental Order. It was Respondents' counsel's belief at that time that to fail to file a Petition to Review would result in a final order of compensability in this matter as it relates to the December 28, 2007 injury.

13. Before attorney's fees may be awarded under Section 8-43-301 (14), C.R.S., the ALJ must make a finding that the Petition to Review was imposed for wrongful purpose. *Lofgren v. Kodak*, W.C. 4-445-606, (ICAO, November 7, 2002). It is not a frivolous appeal and attorney's fees should not be awarded if a party makes a "good faith argument for the extension, modification, or reversal of existing law." *Waymire v. City of Las Animas*, WC 4-142-136 (ICAO July 21, 1995). An appeal is only frivolous if there is no rational argument, based in law or the evidence, which could support the appeal. *Tozer v. Scott Wetzel Services, Inc.*, 882 P.2d 496 (Colo. App. 1994).

14. Respondents believed that the Supplemental Order as to compensability would be final if they did not file the petition as instructed to do in the Supplemental *Order*. Respondents Petition to Review was not filed for wrongful purposes nor was it frivolous.

ORDER

It is therefore ordered that:

1. Respondents are responsible for the expenses incurred at HealthOne Rose Medical Center and Dr. Shogan for the surgery performed on January 3, 2008 as a result of the compensable December 28, 2007 injury.

2. Dr. Shogan and his referrals are authorized to treat the compensable December 28, 2007 injury.

3. Respondents stipulate that Claimant was unable to work as a result of the back injury from December 28, 2007 through February 15, 2008. Respondents shall pay Claimant TTD for this time period.

4. Claimant's claim for compensation and benefits for an October 26, 2008 injury (W.C. No. 4-796-319) is denied and dismissed. Claimant's claim for TTD from 11/10/08 through 1/12/09 is denied and dismissed. Claimant's claim for medical treatment for this injury is denied and dismissed.

5. Neither Claimant nor Respondents listed average weekly wage as an issue for determination. Therefore, in the event the parties are unable to stipulate on this issue, they may set it for hearing.

6. Claimant's request for attorney's fees pursuant to Section 8-43-301 (14), C.R.S. for Respondents' improperly filed Petition to Review Judge Jones' Supplemental Order of December 16, 2008 is denied and dismissed.

7. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

8. All matters not determined herein are reserved for future determination.

DATED: October 21, 2009

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-790-518

ISSUES

1. Whether Claimant was an "employee" or an "independent contractor" under the Workers' Compensation Act of Colorado while working as a cab driver for Employer on April 1, 2009.

2. Whether Claimant has proven by a preponderance of the evidence that he suffered compensable injuries during the course and scope of his employment with Employer on April 1, 2009.

3. Whether Claimant has demonstrated by a preponderance of the evidence that he is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

4. A determination of Claimant's Average Weekly Wage (AWW).

5. Whether Claimant has established by a preponderance of the evidence that he is entitled to receive Temporary Total Disability (TTD) benefits for the period April 2, 2009 through June 4, 2009.

FINDINGS OF FACT

1. On October 26, 2007 Claimant began working for Employer as a cab driver. He executed an Independent Contractor and Lease Agreement (Agreement) with Employer. Under the terms of the Agreement Claimant leased a specially equipped vehicle from Employer and agreed to pay scheduled lease amounts to Employer. Claimant was required to use the vehicle exclusively as a taxicab in accordance with applicable state regulations. Employer also made a dispatching service available to Claimant. However, Claimant was not obligated to accept every passenger or to perform services exclusively for Employer.

2. Claimant was required to obtain insurance coverage at his own expense. Claimant purchased insurance coverage under a Blanket Accident Insurance Policy issued through AIG (AIG Policy). The AIG Policy provided an accidental death benefit of $50,000 and an accidental dismemberment benefit of $150,000 for a period of one year. The Policy also permitted a weekly accident indemnity benefit of up to $350.00 for a maximum of one year after a seven-day waiting period. The AIG Policy also provided medical benefits in the form of treatment, prescriptions, hospitalizations, testing and durable medical equipment. However, the AIG Policy limited medical benefits to $300,000 for a maximum period of one year.

3. On April 1, 2009 Claimant was involved in a single vehicle accident while driving his taxicab. He was traveling on a highway at approximately 55 miles per hour, lost control of his vehicle and crashed into a median.

4. On April 3, 2009 Claimant visited Denver Health Medical Center for injuries sustained in the April 1, 2009 accident. He reported right-sided pain, lower back pain and knee pain. Claimant's chest x-ray and head CT scan were negative. He was discharged without any limitations or restrictions.

5. On April 6, 2009 Claimant visited chiropractor Steve C. Visentin, D.C. He reported lumbar, thoracic and cervical spine pain. Dr. Visentin subsequently ordered imaging studies of Claimant's spine.

6. On April 6, 2009 chiropractor Margaret A. Seron, D.C. prepared a radiology report about the imaging studies of Claimant's spine. The studies revealed that Claimant had a normal thoracic spine. In terms of his lumbar spine Dr. Seron found flat-

tened lumbar lordosis, “very early endplate osteophyte formation” at L2-5 and very early spondylosis. She did not attribute the findings to a traumatic event, but noted that Claimant’s right leg was shorter than his left. In addressing Claimant’s cervical spine, Dr. Seron noted that Claimant’s cervical disc heights were well-maintained with adequate bone density. However, the findings suggested “muscle spasm and imbalance with resulting cervical kinetics.” Dr. Seron did not offer an opinion about the cause of the cervical findings.

7. On April 23, 2009 Claimant returned to Dr. Visentin for an evaluation. Dr. Visentin completed a form reflecting that Claimant was disabled for the period April 1, 2009 through April 15, 2009. He also stated in a second form that Claimant was disabled for the period from April 15, 2009 through April 29, 2009. Dr. Visentin noted that Claimant “had not improved enough to work yet.”

8. On May 13, 2009 Claimant again visited Dr. Visentin. Dr. Visentin remarked that he was continuing to provide “chiropractic care for spinal injuries.” He noted that Claimant was disabled for the period May 13, 2009 through May 27, 2009. Dr. Visentin reiterated that Claimant “has improved under my care, but not enough to return to work yet.”

9. On May 27, 2009 Dr. Visentin issued a notice specifying that Claimant could resume his job duties effective June 4, 2009.

10. Claimant testified at the hearing in this matter that he earned an AWW of $754.81 while working for Employer. Schedule C of Claimant’s 2008 Federal Income Tax Return provided that Claimant earned gross receipts of $39,250 as a taxicab driver. His expenses totaled $7,050.00 and his vehicle lease cost $25,300.00. Claimant thus reported net earnings from self-employment of $6,372.00.

11. Claimant was an employee while working as a taxi driver for Employer on April 1, 2009. The AIG Policy did not provide benefits that were “at least comparable” to the benefits available under Colorado’s Workers’ Compensation system. The Policy provided a weekly accident indemnity benefit of up to $350.00 for a maximum of one year after a seven-day waiting period. Moreover, the AIG Policy limited medical benefits to $300,000 for a maximum period of one year. In contrast, Colorado’s Workers’ Compensation system has no aggregate limit on indemnity or medical benefits. Relying on *Aligaze v. Colorado Cab Co./Veolio Transportation,* W.C. No. 4-705-940 (ICAP, Apr. 29, 2009), the preceding differences are sufficient to establish that the AIG Policy does not provide coverage “comparable” to Colorado’s Workers’ Compensation system within the meaning of §40-11.5-102, C.R.S. and §8-40-301, C.R.S. Therefore, it is unnecessary to address whether Claimant was an employee under the criteria set forth in §8-40-202, C.R.S.

12. Claimant has demonstrated that it is more probably true than not that he suffered compensable injuries during the course and scope of his employment with Employer on April 1, 2009. On April 1, 2009 Claimant was involved in a single vehicle accident while driving his taxicab. He was traveling on a highway at approximately 55 miles

per hour, lost control of his vehicle and crashed into a median. He subsequently visited Denver Health Medical Center. Claimant reported right-sided pain, lower back pain and knee pain as a result of the April 1, 2009 incident.

13. Claimant has established that it is more probably true than not that he is entitled to receive authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his April 1, 2009 industrial injuries. On April 3, 2009 Claimant visited Denver Health Medical Center for treatment. After an examination and diagnostic testing he was discharged. Claimant subsequently received chiropractic treatment for his industrial injuries from Dr. Visentin. Dr. Visentin continued to treat Claimant for spinal injuries through May 27, 2009. A review of the record reveals that Dr. Visentin's treatment and referrals were reasonable and necessary to relieve the effects of Claimant's industrial spine injuries.

14. Claimant credibly testified that he earned an AWW of $754.81 while working for Employer. Schedule C of Claimant's 2008 Federal Income Tax Return corroborates Claimant's testimony. An AWW of $754.81 thus constitutes a fair approximation of Claimant's wage loss and diminished earning capacity.

15. Claimant has proven that it is more probably true than not that he sustained industrial injuries to his spine that caused a subsequent wage loss. The medical records of Dr. Visentin reveal that Claimant suffered a disability that impaired his ability to effectively and properly perform his regular employment. Dr. Visentin completed forms reflecting that Claimant was disabled for the period April 1, 2009 through May 27, 2009. He ultimately released Claimant to perform regular job duties effective June 4, 2009. Therefore, Claimant is entitled to receive TTD benefits for the period April 2, 2009 through June 4, 2009.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Independent Contractor/Employee

4. Respondents contend that Claimant was an independent contractor who performed services for Employer. The dispute in this matter thus involves the construction of §§8-40-202, 8-40-301 and 40-11.5-102, C.R.S. (2009). Courts must construe Colorado's Workers' Compensation Act as a whole to give consistent, harmonious and sensible effect to all of its parts. *Monfort Transportation v. ICAO*, 942 P.2d 1358, 1360 (Colo. App. 1997). Subsection 8-40-202(2)(c), C.R.S. provides that "[n]othing in this section shall be construed to conflict with section 8-40-301 or to relieve any obligations imposed pursuant thereto." Subsection 8-40-301(5), C.R.S. states that "*'[e]mployee' excludes any person who is working as a driver under a lease agreement* pursuant to 40-11.5-102 C.R.S., *with a common carrier or contract carrier*" (emphasis added). Subsection 8-40-301(6), explains that "[a]ny person working as a driver with a common carrier or contract carrier as described in this section *shall be eligible for and shall be offered* workers' compensation insurance coverage by Pinnacol Assurance or *similar coverage* consistent with the requirements set forth in section 40-11.5-102(5), C.R.S" (emphasis added). Subsection 40-11.5-102(5)(a), states that '[a]ny lease or contract executed pursuant to this section shall provide for coverage under workers' compensation or a private insurance policy that provides similar coverage." "'[S]imilar coverage' means disability insurance for on and off the job injury . . . *[and] such insurance coverage shall be at least comparable to the benefits offered under the workers' compensation system.*" §40-11.5-102(5)(b) (emphasis added).

5. Because Employer is a common carrier or contract carrier and Claimant worked for Employer as a driver pursuant to §40-11.5-102, C.R.S. he is excluded from the definition of "employee." He is thus presumed to be an "independent contractor" in the absence of clear and convincing evidence. *See Gebrekidan v. MKBS, LLC,* W.C. No. 4-678-723 (ICAO, May 10, 2007). However, pursuant to §40-11.5-102(5)(a), C.R.S. a lease agreement that excludes a driver from the definition of "employee" must provide workers' compensation coverage or a private insurance policy that offers similar coverage.

6. In *USF v. Industrial Claim Appeals Office,* 111 P.3d 529 (Colo. App. 2005) the Colorado Court of Appeals addressed the issue of whether a claimant's failure to secure complying insurance coverage changed his status from an independent contractor to an employee. In reviewing the statutory scheme, the Court reasoned that the exclusion of leased drivers as employees in §8-40-301(5) only takes effect when the lease agreement includes complying coverage. *Id.* at 533. The Court of Appeals determined that the alleged independent contractor agreement and the insurance coverage made

available to the driver violated the requirement that the common carrier must provide either Workers' Compensation coverage or similar coverage for the driver. *Id.* Because the required coverage was not provided, the Court determined that the claimant was automatically an "employee" of USF who was eligible for Workers' Compensation benefits directly through USF. *Id.* at 533-34. The Court of Appeals specifically noted:

> Accordingly, we conclude that claimant could establish his status as an "employee" of respondent for purposes of the Act either by overcoming the presumption created under section 40-11.5-102(4) with clear and convincing proof or by showing that he was not offered coverage that satisfied the requirements set forth in section 40-11.5-102(5). Because claimant established that the policy negotiated through respondent did not comply with those requirements, we need not reach the issue of whether he otherwise established the existence of an employment relationship.

Id. at 533-34.

7. In *Aligaze v. Colorado Cab Co./Veolio Transportation,* W.C. No. 4-705-940 (ICAP, Apr. 29, 2009), the Panel considered whether a taxicab driver was an independent contractor or employee. Addressing *USF,* the Panel noted that a driver can establish his status as an employee either by overcoming the presumption of independence in §40-11.5-102(4), C.R.S. or showing that he was not offered coverage that satisfied the requirements of §40-11.5-102(5), C.R.S. The Panel reviewed the driver's insurance policy and concluded that it did not provide benefits "comparable to the benefits under the Workers' Compensation system" because the policy limited medical benefits and compensation.

8. As found, Claimant was an employee while working as a taxi driver for Employer on April 1, 2009. The AIG Policy did not provide benefits that were "at least comparable" to the benefits available under Colorado's Workers' Compensation system. The Policy provided a weekly accident indemnity benefit of up to $350.00 for a maximum of one year after a seven-day waiting period. Moreover, the AIG Policy limited medical benefits to $300,000 for a maximum period of one year. In contrast, Colorado's Workers' Compensation system has no aggregate limit on indemnity or medical benefits. Relying on *Aligaze v. Colorado Cab Co./Veolio Transportation,* W.C. No. 4-705-940 (ICAP, Apr. 29, 2009), the preceding differences are sufficient to establish that the AIG Policy does not provide coverage "comparable" to Colorado's Workers' Compensation system within the meaning of §40-11.5-102, C.R.S. and §8-40-301, C.R.S. Therefore, it is unnecessary to address whether Claimant was an employee under the criteria set forth in §8-40-202, C.R.S.

Compensability

9. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re*

Swanson, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

10. As found, Claimant has demonstrated by a preponderance of the evidence that he suffered compensable injuries during the course and scope of his employment with Employer on April 1, 2009. On April 1, 2009 Claimant was involved in a single vehicle accident while driving his taxicab. He was traveling on a highway at approximately 55 miles per hour, lost control of his vehicle and crashed into a median. He subsequently visited Denver Health Medical Center. Claimant reported right-sided pain, lower back pain and knee pain as a result of the April 1, 2009 incident.

Medical Benefits

11. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

12. As found, Claimant has established by a preponderance of the evidence that he is entitled to receive authorized medical treatment that is reasonable and necessary to cure and relieve the effects of his April 1, 2009 industrial injuries. On April 3, 2009 Claimant visited Denver Health Medical Center for treatment. After an examination and diagnostic testing he was discharged. Claimant subsequently received chiropractic treatment for his industrial injuries from Dr. Visentin. Dr. Visentin continued to treat Claimant for spinal injuries through May 27, 2009. A review of the record reveals that Dr. Visentin's treatment and referrals were reasonable and necessary to relieve the effects of Claimant's industrial spine injuries.

Average Weekly Wage

13. Section 8-42-102(2), C.R.S. requires the Judge to determine a claimant's AWW based on her earnings at the time of injury. The Judge must calculate the money rate at which services are paid to the claimant under the contract of hire in force at the time of injury. *Pizza Hut v. ICAO,* 18 P.3d 867, 869 (Colo. App. 2001). However, §8-42-102(3), C.R.S. authorizes a Judge to exercise discretionary authority to calculate an AWW in another manner if the prescribed methods will not fairly calculate the AWW based on the particular circumstances. *Campbell v. IBM Corp.,* 867 P.2d 77, 82 (Colo. App. 1993). The overall objective in calculating an AWW is to arrive at a fair approximation of a claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997).

14. As found, Claimant credibly testified that he earned an AWW of $754.81 while working for Employer. Schedule C of Claimant's 2008 Federal Income Tax Return corroborates Claimant's testimony. An AWW of $754.81 thus constitutes a fair approximation of Claimant's wage loss and diminished earning capacity.

Temporary Total Disability Benefits

15. To obtain TTD benefits, a claimant must establish a causal connection between a work-related injury and a subsequent wage loss. §8-42-103(1)(a), C.R.S. To demonstrate entitlement to TTD benefits a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The term "disability," connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earning capacity as demonstrated by a claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). A claimant suffers from an impairment of earning capacity when she has a complete inability to work or there are restrictions that impair his ability to effectively and properly perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998).

16. As found, Claimant has proven by a preponderance of the evidence that he sustained industrial injuries to his spine that caused a subsequent wage loss. The medical records of Dr. Visentin reveal that Claimant suffered a disability that impaired his ability to effectively and properly perform his regular employment. Dr. Visentin completed forms reflecting that Claimant was disabled for the period April 1, 2009 through May 27, 2009. He ultimately released Claimant to perform regular job duties effective June 4, 2009. Therefore, Claimant is entitled to receive TTD benefits for the period April 2, 2009 through June 4, 2009.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant was an employee of Employer on April 1, 2009.

2. Claimant suffered compensable spinal injuries during the course and scope of his employment with Employer on April 1, 2009.

3. Claimant is entitled to reasonable and necessary medical benefits designed to cure and relieve the effects of his industrial injuries.

4. Claimant earned an AWW of $754.81.

5. Claimant is entitled to receive TTD benefits for the period April 2, 2009 through June 4, 2009.

6. Any issues not resolved in this Order are reserved for future determination.

DATED: October 21, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-758-052

ISSUES

¬ Did claimant prove by a preponderance of the evidence that the Judge should penalize Respondent-Employer Boulder Trip Service, LLC, for violation of an order?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

Respondent-Employer , LLC, operates a limousine business. Claimant worked for employer as a limousine driver. On November 28, 2007, claimant sustained injuries arising out of a motor vehicle accident (MVA) when the limousine he was driving was rear-ended by another vehicle.

On June 5, 2008, Respondent-Employer , LLC, filed a General Admission of Liability (GAL), admitting liability for medical benefits. The GAL obligates Respondent-Employer , LLC, to pay, pursuant to fee schedule, for medical treatment that is reasonably necessary to cure and relieve the effects of claimant's injury.

On September 17, 2008, claimant and Respondent-Employer , LLC, entered into a Stipulation, agreeing to resolve issues of average weekly wage (AWW) and temporary total disability (TTD) benefits. The parties agreed that Respondent-Employer , LLC, would pay claimant $650.00 per week, which includes claimant's TTD benefits and a 50% increase in compensation to reflect a penalty based upon employer's failure to insure for benefits under the Act.

On September 22, 2008, Prehearing Administrative Law Judge Craig C. Eley (PALJ Eley), entered an **Order Regarding Stipulation**, making the parties' Stipulation an "Order of the Court". PALJ Eley thus ordered Respondent-Employer , LLC, to pay claimant past and ongoing TTD benefits pursuant to the Stipulation.

Under the terms of the Stipulation, Respondent-Employer , LLC, agreed to pay claimant TTD benefits at the weekly rate of $650.00 from November 28, 2007, ongoing until claimant met one of the criteria for termination of TTD benefits under §8-42-105(3), C.R.S. By cashier's check dated October 1, 2008, Respondent-Employer , LLC, paid claimant $13,600.00, which represents a payment toward past TTD benefits. Respondent-Employer , LLC, failed to make any payment toward TTD benefits due claimant under the terms of the Stipulation from October 1, 2008, ongoing.

Crediting claimant's testimony, the Judge finds: Claimant's current symptoms include headaches, back pain from his lower back up into his neck, fatigue, depression, rotator cuff problems in his left shoulder, sinus problems. Respondent-Employer , LLC, has failed to pay for claimant's medical treatment, such that his treating physicians refuse to treat him. Claimant has not worked since the time of the MVA and believes he is unable to work. There was no persuasive evidence otherwise showing that claimant has met one of the criteria for termination of TTD benefits under §8-42-105(3), *supra*.

On July 13, 2009, PALJ Eley entered an **Order Naming CE As An Individual Respondent**. Under this Order, PALJ Eley joined CE as an individual respondent and ordered the caption amended as follows: "JS and CE, individually and jointly, d/b/a , Respondent employer".

While Respondent-Employer, LLC, has filed a GAL and has stipulated to its liability as claimant's employer, the liability of JS and CE remains unadjudicated and undetermined.

As of the time of hearing, Respondent-Employer, LLC, owes claimant $35,750.00 in TTD benefits, unpaid over 385 days from October 1, 2008, plus $1,492.14 in statutory interest. Respondent-Employer, LLC, thus owes claimant a lump sum of $37,242.14 in unpaid TTD benefits and interest.

Respondent-Employer, LLC, through counsel, contends it has been unable to pay claimant his benefits under the Stipulation.

Claimant showed it more probably true than not that Respondent-Employer , LLC, has violated the order of PALJ Eley by failing to pay claimant compensation benefits it agreed to pay pursuant to the Stipulation from October 1, 2008, ongoing. As of the date of hearing, Respondent-Employer, LLC, had violated the order of PALJ Eley, each day for 385 days. The Judge finds that claimant's daily TTD rate of $61.84 ($650 x .666 = 432.90, divided by 7) provides a fair approximation of the harm and prejudice he has suffered because of the failure of Respondent-Employer, LLC, to pay compensation under the terms of the Stipulation, and as ordered by PALJ Eley.

Respondent-Employer, LLC, should pay a penalty in the amount of $25,808.40 ($61.84 x 385 days), 25% payable to the Subsequent Injury Fund and 75% payable to claimant.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Claimant argues he has proven by a preponderance of the evidence that the Judge should penalize Respondent-Employer, LLC, for violation of PALJ Eley's order. The Judge agrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

Section 8-43-304(1), *supra*, authorizes the imposition of penalties up to $500 per day where a party fails, refuses, or neglects to obey a lawful order or to perform any duty lawfully enjoined or mandated within the time prescribed by the director or administrative law judge (ALJ). This statute thus encompasses an order issued by an ALJ. *Holiday v. Bestop, Inc.*, 23 P.3d 700 (Colo. 2001); *Giddings v. Indus. Claim Appeals Office*, 39 P.3d 1211 (Colo. App. 2001). Likewise, the term "order" as used in this penalty provision includes a rule of the director. *Spracklin v. Indus. Claim Appeals Office*, 66 P.3d 176 (Colo. App. 2002). Section 8-43-304(1) thus identifies four categories of conduct and authorizes the imposition of penalties when an employer or insurer: (1) Violates any provision of the Act; (2) does any act prohibited by the Act; (3) fails or refuses to perform any duty lawfully mandated within the time prescribed by the director or Panel; or (4) fails, neglects, or refuses to obey any lawful order of the director or Panel. *Pena v. Industrial Claim Appeals Office*, 117 P.3d 84 (Colo. App. 2005).

For purposes of §8-43-304(1), an insurer neglects to obey an order if it fails to take the action a reasonable insurer would take to comply with the order. The reasonableness of the insurer's actions depends upon whether such actions were predicated upon a rational argument based in law or fact. *Diversified Veterans Corporate Center v. Hewuse,* 942 P.2d 1312 (Colo. App. 1997). Insurer must advance a rational argument to support the reasonableness of its actions. *See Pueblo School District No. 70 v. Toth,* 924 P.2d 1094 (Colo. App. 1996).

Here, the Judge found claimant showed it more probably true that Respondent-Employer , LLC, has violated the order of PALJ Eley by failing to pay claimant compensation benefits it agreed to pay pursuant to the Stipulation from October 1, 2008, ongoing. Claimant thus proved by a preponderance of the evidence Respondent-Employer , LLC, should be penalized for such violation.

The Judge found that Respondent-Employer, LLC, has violated the order of PALJ Eley, each day for 385 days. The Judge determined that claimant's daily TTD rate of $61.84 provides a fair approximation of the harm and prejudice he has suffered because of the failure of Respondent-Employer, LLC, to pay compensation as ordered by PALJ Eley. The Judge thus found that Respondent-Employer, LLC, should pay a penalty in the aggregate amount of $25,808.40. Pursuant to §8-43-304(1), *supra*, any penalty is payable 25% to the Subsequent Injury Fund and 75% to claimant.

The Judge concludes that Respondent-Employer, LLC, should pay claimant a lump sum of $37,242.14 in unpaid TTD benefits and interest through the date of hearing. The Judge further concludes that Respondent-Employer, LLC, should pay a penalty in the amount of $5,952.10 to the Subsequent Injury Fund and in the amount of $17,856.30 to claimant.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Respondent-Employer, LLC, shall pay claimant a lump sum of $37,242.14 in unpaid TTD benefits and interest due through the date of hearing.

2. Respondent-Employer, LLC, shall pay a penalty in the aggregate amount of $25,808.40 as follows: $5,952.10 to the Subsequent Injury Fund and $17,856.30 payable to claimant.

3. Respondent-Employer, LLC, shall pay the Director of the Division of Workers' Compensation on behalf of the Subsequent Injury Fund as follows: Respondent-Employer, LLC, shall issue any check payable to "Subsequent Injury Fund" and shall mail the check to the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: Subsequent Injury Fund.

4. Respondent-Employer, LLC, shall pay, pursuant to fee schedule, for medical treatment that is reasonably necessary to cure and relieve the effects of claimant's injury.

5. Respondent-Employer, LLC, shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

6. Issues not expressly decided herein are reserved to the parties for future determination.

7. In lieu of payment of the above compensation and benefits to the claimant, the Respondent-Employer shall:

a. Deposit the sum of $65,000.00 with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to: Division of Workers' Compensation/Trustee. The check shall be mailed to the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: /Trustee; or

b. File a bond in the sum of $65,000.00 with the Division of Workers' Compensation within ten (10) days of the date of this order:
   (1) Signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation; or
   (2) Issued by a surety company authorized to do business in Colorado.
   The bond shall guarantee payment of the compensation and benefits awarded.

IT IS FURTHER ORDERED: That the Respondent-Employer shall notify the Division of Workers' Compensation of payments made pursuant to this order.

IT IS FURTHER ORDERED: That the filing of any appeal, including a petition to review, shall not relieve the employer of the obligation to pay the designated sum to the trustee or to file the bond. §8-43-408(2), *supra*.

DATED: _October 21, 2009_

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-774-366

ISSUES

The issues for determination are compensability, medical benefits, disfigurement, average weekly wage, temporary total disability benefits from 9/8/08 to 2/16/09, permanent partial disability benefits, and pre-existing condition.

FINDINGS OF FACT

1. Claimant was employed by employer as a fourth-year apprentice electrician during 2008.

2. During May and June, 2008, claimant worked on employer's Pellaton project. As only a part of his duties, claimant operated a hammer drill.

3. In July, 2008, claimant was transferred to employer's Embassy Suites project. As part of his duties, claimant was occasionally required to lift, bend, twist, rotate, push, pull, and carry items.

4. From May through August, 2008, claimant worked full time, on full duty. He never reported any physical problems and never requested modified or restricted duty, time off, or medical treatment.

5. On Friday, September 5, 2008, claimant left work early, allegedly due to shoulder pain and a persistent headache. Claimant did not, however, report a work-related injury or request medical treatment.

6. Over the weekend, claimant played with his grandchildren and went swimming.

7. On Monday, September 8, 2008, claimant awoke with severe neck pain. He scheduled an appointment with his personal physician, Dr. Domaleski, then called employer to advise that he had hurt his neck, and that he would not be able to work that day. Karen Mueller, employer's office manager, asked claimant if his injury was work-related. Claimant stated he thought he hurt it at home, and was not work-related.

8. On September 9, 2009, claimant saw Dr. Domaleski. Dr. Domaleski noted claimant suffered from degenerative disc disease in his cervical spine, and suspected claimant had a herniated disc. He recommended claimant undergo an MRI.

9. On September 10, 2008, claimant spoke to Hiester, employer's safety manager. Claimant advised Mr. Hiester that Dr. Domaleski recommended an MRI. Mr. Hiester asked claimant if his injury was work-related. Claimant stated that he did not know if he had hurt himself at home or at work. Mr. Hiester then spoke with Richard King, employer's claims manager. Mr. King advised Mr. Hiester to get specific details surrounding claimant's injury, and asked that Mr. Hiester specifically ask claimant if this was a work-related injury. Mr. Hiester called claimant back, specifically asked if he was reporting a work-related injury, and advised claimant that if he wished to report a work-related injury, that this was the time to do so. Claimant again stated that he was unsure if he hurt himself at home or at work, and wished to pursue treatment through his private insurance. Mr. Hiester contemporaneously recorded these conversations in his daily journal.

10. On September 12, 2008, Dr. Domaleski prescribed physical therapy.

11. On September 17, 2008, claimant underwent an MRI. The images revealed degenerative disc disease, with a broad-based C6-7 disc/osteophyte complex.

12. On September 18, 2008, Dr. Domaleski referred claimant for a neurosurgical consultation.

13. On the morning of September 19, 2009, claimant spoke to Mang, employer's Field Superintendent at that time, and advised Mr. Mang that his physician had taken him off work indefinitely. Claimant stated again that he did not know if he injured himself at home or at work. Mr. Mang contemporaneously recorded this conversation in an email. (Respondents' Hearing Submission O.)

14. That afternoon, claimant met in-person with Mr. Mang. Claimant gave Mr. Mang documentation from Dr. Domaleski and advised Mr. Mang again that he was not sure if he injured himself at home or at work. Mr. Mang contemporaneously noted on the medical documents that claimant's injury was not work related. (Respondents' Hearing Submission D.)

15. Claimant had several conversations with Karen Mueller, employer's office manager regarding claimant's private insurance questions and administrative details surrounding claimant's medical leave. Ms. Mueller was also involved in workers' compensation matters for employer. Ms. Mueller testified that during each conversation with claimant, she asked claimant if his injury was work-related. Each time, claimant stated he was unsure if it was work-related or not.

16. On September 23, 2008, claimant was seen for a neurosurgical consultation by Dr. Drewek. He found claimant had a herniated disc at C6-7, and recommended an epidural steroid injection. He also discussed the possibility of surgery with claimant.

17. On September 30, 2008, claimant underwent an epidural steroid injection, which was unsuccessful.

18. On October 15, 2008, claimant was seen by both Dr. Drewek and Dr. Domaleski. Dr. Drewek recommended claimant undergo a cervical diskectomy and fusion at C6-7. Claimant agreed to the surgery and scheduled it without employer's knowledge or consent.

19. On October 16, 2008, claimant completed his initial Worker's Claim for Compensation, but did not present it to employer or file it with the Department of Labor.

20. On October 27, 2008, claimant's attorney sent a letter to employer, enclosing the Workers' Claim for Compensation, which had not previously been provided to employer.

21. On October 31, 2008, Dr. Drewek performed a successful C6-7 diskectomy and fusion on claimant without the prior authorization of the employer or insurer.

22. On November 3, 2008, seven days after receiving the workers' claim for compensation, Mr. Hiester met with claimant in person, at claimant's home. At that time, Mr. Hiester presented claimant with a list of designated medical providers. Claimant selected a provider, and signed the form. (Respondents' Hearing Submission U.)

23. Neither Dr. Domaleski nor Dr. Drewek ever opined that claimant's injury was work-related. In response to the specific question, Dr. Domaleski stated that it was a mere possibility that claimant's work could have contributed to his injury. However, this opinion was not given to a reasonable degree of medical probability. (Respondents' Hearing Submission G.) Claimant also testified that neither physician ever told him his injury was caused by his work activities.

24. On April 23, 2009, Dr. Ryan examined claimant. Dr. Ryan opined that claimant's use of the hammer drill more probably than not aggravated his degenerative condition and caused his injury. This opinion is not persuasive. Dr. Ryan's report fails to explain the delay in the onset of symptoms or how the use of the hammer drill otherwise accelerated or aggravated claimant's pre-existing condition. Dr. Ryan points to no acute event or other trauma that would have caused claimant's condition.

25. On May 28, 2009, Dr. Fall examined claimant. Claimant could not tell Dr. Fall when his injury happened, or the circumstances leading up to the injury, and did not relate any acute incident as the cause. Dr. Fall opined that claimant's injury was the result of the natural progression of his degenerative condition, and was not related to his work. Dr. Fall further opined that claimant's job activities, including the use of the hammer drill, would not accelerate or aggravate his pre-existing degenerative condition. She stated that repetitive or cumulative actions may elicit symptoms, but does not accelerate degeneration, or otherwise aggravate degenerative disc disease. Dr. Fall further stated that it is common for individuals who suffer from degenerative disc disease to sustain herniated discs without acute trauma, regardless of their work activities. Because claimant could not point to a specific acute trauma, and could not state under what circumstances his injury occurred, she opined that claimant's injury was caused by the natural progression of his underlying degenerative condition. Dr. Fall's testimony and opinion is persuasive.

CONCLUSIONS OF LAW

1. In order to prove entitlement to benefits, a claimant must show by a preponderance of the evidence that his injury was caused by activities that arose out of and in the course of his employment. § 8-43-201, C.R.S. (2008); § 8-41-301(1)(c), C.R.S. (2008).

2. "Proof by a preponderance of the evidence requires [claimant] to establish that the existence of a 'contested fact is more probable than its nonexistence.'" *Matson v. CLP, Inc.*, W.C. No. 4-772-111 (ICAO August 13, 2009) (quoting *Page v. Clark*, 592 P.2d 792, 800 (Colo. 1979).

3. When a claimant suffers from a pre-existing condition, he must prove by a preponderance of the evidence that his employment activities accelerated or aggravated the condition, and that his injury was not merely the result of the condition's natural progression. *H&H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990).

4. The mere experience of symptoms at work does not require a finding that the work activities accelerated or otherwise aggravated a pre-existing condition. *Harris v. Golden Peaks Nursing*, W.C. No. 4-680-878 (ICAO June 4, 2008); *Cotts v. Exempla*, W.C. No. 4-606-563 (ICAO August 18, 2005).

5. Here, claimant has failed to meet the required burden of proof. Claimant has not presented pursuasive evidence that his injury was caused by his work-related activities.

6. Claimant's testified that he was initially unsure if he hurt himself at home or at work, and that he did not want to pursue workers' compensation benefits. He also testified that he later believed his injury was work-related after he discovered the severity of his injury, and was advised that he may have to undergo surgery. Claimant's treating physicians never gave a contemporaneous opinion on the cause of claimant's injury. Therefore, no new information as to the cause of the injury was available to claimant from the time he first could not work until he first believed his injury was work-related. Claimant's testimony reveals that it was the prospect of surgery that caused him to seek workers' compensation benefits, not a belief that his injury was work-related. Claimant's testimony is not credible evidence of a causal connection between his work activities and his injury.

7. Dr. Allison Fall credibly testified that claimant's work activities did not accelerate or aggravate claimant's pre-existing degenerative condition. She stated that repetitive or cumulative actions may elicit symptoms, but does not accelerate degeneration, or otherwise aggravate degenerative disc disease. Dr. Fall further stated that it is common for individuals who suffer from degenerative disc disease to sustain herniated discs without acute trauma, regardless of their work activities. Because claimant could not point to a specific acute trauma, and could not state under what circumstances his injury occurred, she opined that claimant's injury was caused by the natural progression of his underlying degenerative condition. Dr. Fall's testimony and opinion is persuasive.

8. The opinion of Dr. Christopher Ryan that claimant's use of the hammer drill caused claimant's injury is not persuasive. Dr. Ryan's report fails to explain the delay in the onset of symptoms or how the use of the hammer drill otherwise accelerated or aggravated claimant's pre-existing condition. Dr. Ryan points to no persuasive acute event or other trauma that would have caused claimant's condition.

9. Claimant failed to show that it is more likely than not his work activities accelerated or aggravated his pre-existing degenerative disc disease. Therefore, he is not entitled to workers' compensation benefits.

10. Notwithstanding the compensability question, claimant is not entitled to medical benefits from Dr. Domaleski and Dr. Drewek. Respondents are liable for all reasonable and necessary medical benefits provided by an authorized treating physician. § 8-42-101(1)(a), C.R.S. (2008); *Popke v. ICAO*, 944 P.2d 677 (Colo. App. 1997).

11. The employer has the right, in the first instance, to select the physician with whom the claimant must treat. § 8-43-404(5), C.R.S. (2008). Once an employer receives "some knowledge of accompanying facts connecting the injury or illness with the employment, [which indicates] to a reasonably conscientious manager that the case might involve a potential compensation claim," the employer must provide claimant with a list of two designated physicians from which the claimant may receive treatment. *Jones v. Adolph Coors Co*, 689 P.2d 681, 684 (Colo. App. 1984); § 8-43-404(5); W.C.R.P. 8.

12. If the required list of designated providers is not tendered, the right to select the treating physician passes to the claimant. § 8-43-404(5). However, a claimant who obtains treatment from an unauthorized physician before notifying his employer of the alleged injury is not entitled to compensation for such treatment. *Zapeicki v. Exabyte Corp.*, W.C. No. 4-539-081 (ICAO January 22, 2004).

13. Respondents did not have notice that claimant's injury might involve a potential workers' compensation claim until they received a letter from claimant's attorney on October 27, 2008. Prior to that date, claimant had indicated in all communications with employer that he did not know if his injury was work-related and had denied a need to be referred to respondents' designated providers.

14. Claimant's argument that he reported his injury as work-related by requesting a urine analysis during the meeting on September 19, 2008 is without merit. Mr. Mang testified that claimant never requested a urine analysis at that meeting. Claimant did not request any of the necessary paperwork, nor did he inquire as to where he should go to obtain the urine analysis.

15. Further, such a request would have been inconsistent with his plain statements, made that same day that he did not know if his injury was work-related. Given these inconsistencies, claimant's request for a urine analysis does not rise to the level of notice required to trigger employer's obligations. To find otherwise would require an employer to ignore a claimant's plain statements on the issue, and act in direct opposition to those plain statements, based only on inference and conjecture. Here, requiring employer to rely on inference and conjecture does not and cannot constitute adequate "knowledge of accompanying facts connecting the injury or illness with the employment, [which indicates] to a reasonably conscientious manager that the case might involve a potential compensation claim." *Jones*, 689 P.2d at 684.

16. Claimant did not provide adequate notice to employer of a work-related injury until October 27, 2008. Employer timely provided claimant with a designated provider list. Therefore, the right to select the physician did not pass to claimant, and all medical benefits provided by Dr. Domaleski and Dr. Drewek is unauthorized.

ORDER

It is therefore ordered that: Claimant's claim for benefits is hereby denied and dismissed.

DATED: October 21, 2009

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-648-312

ISSUES

The issues determined herein are safety rule offset and disfigurement benefits.

FINDINGS OF FACT

1. Claimant has been a journeyman lineman since 1977. He has worked for the employer for multiple time periods. He most recently worked for the employer for approximately one and one-half years. In his capacity as a foreman for the employer, Claimant's responsibilities included holding a tailgate meeting with the crew at the start of the day to review safety rules, equipment and hazards.

2. The employer had reasonable safety rules. Rule 3.2, "Rubber Gloving," provided:

> When working on energized apparatus exceeding 1001 volts, gloves and sleeves must be utilized.
> (a) Rubber gloves shall be worn for all voltages over fifty (50) volts.

The employer also had another rule on page 48 of the safety manual:

> When primary compartments on energized pad-mounted enclosures are opened, they shall be considered a hazard and all safety rules pertaining to an energized condition, including eye protection and rubber gloves, shall apply.

3. On April 26, 2005, Claimant sustained an admitted electrical shock injury while installing a pull line in an energized electrical cabinet. A pull line is a thin string with a birdie on the end of it. The line is fed from one side of an electrical cabinet and is grabbed from underneath the cabinet with a stick with a hook on it called a shotgun. Approximately three feet of air space exists between the ground and the bottom of the cabinet.

4. Claimant and his crew were working on a switch cabinet when electrical power was flowing through the cabinet. The voltage was at a level of 7000 volts. Claimant removed a “baffle” to permit better light for the coemployee to grab the pull line that claimant was feeding into the cabinet. The baffle was a red, hanging barrier, and had on it a sticker warning that behind it were wires connected to electrical power. Claimant admitted that he did not wear rubber gloves while working on the energized pad-mounted cabinet. Claimant stood inside a 14” space between underground cabinets and the front of the pad-mounted cabinet. He had his arms in front of his body, feeding a pull string into conduit inside the pad-mounted cabinet. He began to manipulate the line when he received an electrical shock injury when a phase to ground circuit was completed through his finger and into his leg. Claimant suspected that the string started the electrical contact because it was wet. He also acknowledged that a ring he was wearing was the contact point.

5. Claimant admitted that he did not wear rubber gloves because he felt that he was 18 inches away from the cabinet and that was out of any danger zone for electrocution. He does not point to any authority for concluding that no danger should be anticipated from that distance.

6. Mr. O’Neil, the field supervisor for the employer, Mr. O’Neill is persuasive that the employer’s safety rules make no reference to any such 18” zone of danger. The zone of danger is defined only in an OSHA rule.

7. Mr. O’Neil testified that the employer’s safety rules applied to the job on which claimant was working. The rules were distributed to all employees. The claimant was a foreman and was responsible for making certain these glove rules were followed. Mr. O’Neil stated that if the clamant had worn the rubber gloves his injury would not have occurred. The claimant did not dispute that wearing rubber gloves would have prevented his injury.

8. Claimant asserted that on many occasions he saw employees, including Mr. O’Neill, work in these circumstances without using rubber gloves. Claimant is not persuasive that Mr. O’Neill had also violated the current rule. Mr. O’Neill was persuasive that he performed similar work without rubber gloves only before the employer’s current rule was effective. Mr. O’Neil credibly testified that he would invoke disciplinary action against any employee he encountered not using rubber gloves as required by this rule.

9. Respondents have proven by a preponderance of the evidence that claimant’s injury resulted from his willful failure to obey a reasonable safety rule of the employer. Claimant’s electrical shock injury resulted from his willful failure to obey the rule requiring rubber gloves for work with an open primary compartment on the energized pad-mounted cabinet.

10. Claimant suffered a serious and permanent bodily disfigurement normally exposed to public view, described as amputation of the left ring finger at the CMC joint,

scarring of the left long finger across the hand to the small finger, and a four-inch by two-inch indented, rough scar on the lower posterior aspect of the left leg.

CONCLUSIONS OF LAW

1. Section 8-42-108, C.R.S. (2004) provides for a discretionary award of benefits up to $2,000 for serious and permanent bodily disfigurement normally exposed to public view. As found, the Judge has determined that, considering the size, location, and general appearance of claimant's disfigurement, he is entitled to the maximum award of $2,000 for disfigurement benefits.

2. Sections 8-42-112(1)(a) and (b), C.R.S. provide a 50% reduction in compensation benefits where respondents prove either that claimant's injury was caused by the willful failure to use safety devices provided by the employer or that the injury resulted from the employee's willful failure to obey any reasonable rule adopted by the employer for the safety of the employee. The safety rule penalty is only applicable if the violation is willful. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office,* 907 P.2d 715 (Colo. App. 1995). Violation of a rule is not willful unless the claimant did the forbidden act with deliberate intention. *Bennett Properties Co. v. Industrial Commission,* 437 P.2d 548 (Colo. 1968); *Stockdale v. Industrial Commission,* 232 P. 669 (Colo. 1925); *Brown* v. Great Peaks, Inc., W.C. No. 4-368-112 (Industrial Claim Appeals Office, July 29, 1999). Respondents satisfy the burden by showing that the employee knew of the rule, but intentionally performed the forbidden act; respondents need not show that the employee, having the rule in mind, determined to break it. *Stockdale v. Industrial Commission*, 76 Colo. 494, 232 P. 669 (1925); *Alvarado v. Industrial Claim Appeals Office* (Colo. App. No. 03CA2498, July 29, 2004) (not selected for publication). As found, respondents have proven by a preponderance of the evidence that claimant's injury resulted from his willful failure to obey a reasonable safety rule of the employer. The insurer is entitled to a 50% reduction in all compensation benefits admitted or ordered to be paid to claimant, including disfigurement benefits.

ORDER

It is therefore ordered that:

1. The insurer shall pay to claimant $2,000 in one lump sum for bodily disfigurement benefits.

2. The insurer is entitled to a 50% reduction in all compensation benefits admitted or ordered to be paid to claimant, including the disfigurement benefits.

3. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

4. All matters not determined herein are reserved for future determination.

DATED: October 22, 2009

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-767-012

ISSUES

¬ Did respondents overcome Dr. Ryan's determination of maximum medical improvement and permanent medical impairment by clear and convincing evidence?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

Employer is a subcontractor providing bus drivers for the Regional Transportation District. Claimant worked for employer as an RTD bus driver. Claimant's date of birth is December 8, 1967; her age at the time of hearing was 41 years.

While driving large passenger buses for employer, claimant was involved in a work-related motor vehicle accident (MVA) on June 3, 2008, and another on July 11, 2008. The June 3, 2008, MVA is denominated W.C. No. 4-767-012; the July 11, 2008, MVA is denominated W.C. No. 4-767-153. Both claims were consolidated for hearing by order of October 13, 2008.

Employer referred claimant to Concentra Medical Centers, where Joel C. Boulder, M.D., treated her. Dr. Boulder initially diagnosed strains to the lumbar, thoracic, and cervical regions of claimant's spine. Dr. Boulder also diagnosed Adjustment Disorder and referred claimant to Cynthia Johnsrud, Psy.D., for a psychological evaluation.

In the course of claimant's treatment, Dr. Boulder referred her to Richard Mobus, D.C., for chiropractic manipulation and treatment of her lumbar, thoracic, and cervical spine. Dr. Mobus treated claimant between August 12th and September 8, 2008.

Claimant sought chiropractic treatment on her own from Kevin Luck, D.C. Dr. Luck referred claimant for magnetic resonance imaging (MRI) scans of her cervical spine and lumbar spine on September 11, 2008.

Dr. Boulder also referred claimant to Physiatrist Allison M. Fall, M.D., for a physical medicine consultation regarding neck and low back pain. Dr. Fall began treating claimant on September 12, 2008. Dr. Fall referred claimant to Mark Testa, D.C., who treated her with biomedical acupuncture, myofascial release techniques, and post isometric stretching. Dr. Testa also reinforced instruction in neck retraction exercises that she initially learned in physical therapy. On October 24, 2008, Dr. Fall opined that

claimant had reached maximum medical improvement (MMI). On November 2, 2008, Dr. Boulder placed claimant at MMI as of October 30th and determined that she sustained no permanent medical impairment. Dr. Boulder recommended maintenance care over the following 6 months to include four acupuncture treatments with Dr. Testa.

On December 12, 2008, insurer filed a Final Admission of Liability, admitting liability for medical benefits in the amount of $5,115.10 and temporary total disability benefits in the amount of $732.66. Based upon Dr. Boulder's November 2nd report, insurer denied liability for permanent partial disability (PPD) benefits. Insurer also denied liability for *Grover*-type medical benefits.

In January of 2009, claimant began culinary arts training at an art institute. Claimant attends 5-hour classes, 3 days per week, during which claimant spends the majority of her time standing. Claimant's training involves some lifting of pans and mixers. Claimant stated in answers to interrogatories:

Washing dishes affects my back because the sink is low, and me having to bend over puts too much stress on my back.

Claimant requested an independent medical examination (DIME) through the Division of Workers' Compensation (DOWC). The division appointed Physiatrist Christopher B. Ryan, M.D., the DIME physician. Dr. Ryan evaluated claimant on March 31, 2009. Claimant reported that she improved substantially with acupuncture treatment. Dr. Ryan diagnosed mechanical cervical pain and mechanical low back pain. Dr. Ryan opined that, while claimant's cervical pain had improved with acupuncture treatment, her lower back pain had been relatively untreated. Dr. Ryan based this opinion upon claimant's report that she received no acupuncture treatment for her lower back. Dr. Ryan determined that claimant had not reached MMI; he wrote:

I would recommend that an acupuncturist be made available to [claimant], in an area of town where she could keep appointments. She may also benefit from reinstruction in exercise. I would recommend that acupuncture be directed towards both areas of the spine, as both areas were injured in the first accident, and both are work related.

Dr. Ryan provided claimant a rating of 26% of the whole person for permanent medical impairment, which combines impairment of the cervical and lumbar regions of her spine. Dr. Ryan's determinations of MMI and rating of 26% are presumptively correct unless overcome by clear and convincing evidence.

Respondents referred claimant to Michael R. Stiplin, M.D., for an independent medical examination on June 25, 2009. Dr. Stiplin testified as an expert in the area of Occupational Medicine and as a Level II physician accredited through DOWC. Dr. Fall testified as an expert in the area of Physical Medicine and Rehabilitation and as a Level II physician accredited through DOWC.

Crediting Dr. Striplin's testimony, the Judge finds: Claimant complained of low back pain radiating up into the thoracic and cervical regions of her spine. Claimant re-

ported that her cervical symptoms had resolved. Claimant thus had no pain originating in her cervical spine as of June 25, 2009. Claimant instead complained of diffuse tenderness in the cervical and bilateral shoulder region, but Dr. Striplin found neither palpable abnormality to support claimant's subjective complaints nor physiologic explanation for claimant's complaints. Dr. Striplin testified:

[Claimant] has subjective complaints of pain with no significant findings. At the time I saw her she was having low back pain only. She made it clear that her neck pain had gone away and that she was having pains in her low back that was radiating into her neck. I reviewed [MRI] studies of her lumbar spine which showed nothing significant. Her physical examination showed no objective findings and so basically I came to the conclusion that she has complaints of pain in the absence of objective findings.

Dr. Striplin's findings mirrored those of Dr. Fall on October 24th, when she determined there were no objective findings to support claimant's complaints of lower back pain. Crediting the medical opinions of Dr. Fall and Dr. Striplin, the MRI findings are normal for claimant's age and clinically unrelated to her complaints from the MVAs.

Dr. Striplin testified that rating claimant's complaints absent anatomic or physiological correlation is inconsistent with the Workers' Compensation Act of Colorado (Workers' Compensation Act), §§8-40-101, *et seq.*, C.R.S. (2009). Dr. Striplin expressly relied upon statutory language of §8-42-101(3.7), which precludes a physician from rating chronic pain absent anatomic or physiological correlation, based upon objective findings. Like Dr. Fall, Dr. Striplin found no evidence of physiological correlation to support diagnosis-based impairment under the Act. Dr. Striplin's medical opinion here was consistent with that of Dr. Fall and was supported by the Act. Dr. Striplin's medical opinion here was persuasive.

Dr. Striplin also explained that rating claimant's complaints absent anatomic or physiological correlation is inconsistent with the *American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Revised)* (AMA Guides). Dr. Striplin testified:

[I]t's very clear when one reads and digests [Chapter 1 of the AMA Guides] that an impairment rating is a process, and the process begins by collecting a history on the patient, doing a physical examination, and then comparing the results of that evaluation with the results that are in the medical record, imaging studies, and what have you.

And, you must reach a conclusion that the patient has a medical condition that you can define and characterize, that that medical condition is producing impairment, and that the condition is stable. And only then do you actually go into the process of opening the AMA guides and referring to tables for purposes of generating a number that represents the impairment.

Dr. Striplin found no evidence in claimant's medical records or imaging studies to support a definable medical condition producing impairment. Dr. Striplin's testimony

here concerning proper use of the AMA Guides for evaluating impairment was persuasive.

Dr. Fall persuasively testified that Dr. Ryan is incorrect in providing claimant a 4% rating for specific disorder of the cervical spine under Table 53 II. B. of the *American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Revised)* (AMA Guides). Dr. Fall stated that Dr. Ryan's assessment of mechanical neck pain is not a diagnosis:

I believe [Dr. Ryan] is wrong because, number one, the patient is at MMI. And, number two, there are no objective findings to warrant a Table 53 diagnosis. His own diagnosis of mechanical neck pain … is a subjective complaint.

Dr. Fall's testimony here was fully supported by Dr. Striplin's medical opinion.

Dr. Striplin also disagreed with Dr. Ryan's determination that claimant meets criteria for a specific diagnosis under Table 53 II. B. of the AMA Guides. Both Dr. Fall and Dr. Striplin testified that Dr. Ryan erred in assigning impairment of the cervical and lumbar regions of claimant's spine. Dr. Striplin persuasively explained that Dr. Ryan erred in assigning claimant values for cervical and lumbar impairment based upon a specific diagnosis under Table 53 of the AMA Guides. Dr. Striplin explained:

[That Table] specifically requires that a person have symptoms for six months, and if [claimant's] problem started in June and resolved in October, then she would not meet the six-month criteria.

Dr. Striplin's testimony here was consistent with the AMA Guides, was supported by Dr. Fall's medical opinion, and was persuasive.

Dr. Fall and Dr. Striplin also disagree with Dr. Ryan relating his diagnosis of recurrent neck pain to the MVAs at employer because the pain occurred later in time after complete resolution of pain and after claimant began activities related to her culinary training in January of 2009.

Dr. Stiplin and Dr. Fall agree that, based upon the history claimant gave them following the MVA of June 3, 2008, claimant sustained no significant injury or symptoms, except headache. Claimant complained of neck and lower back pain of undeterminable etiology after she returned to work. Based upon this history, Dr. Fall and Dr. Striplin agreed it medically improbable that claimant's neck and lower back complaints were related to the June 3rd MVA. Dr. Fall and Dr. Striplin also agreed that the July 11th MVA was insignificant and that claimant's symptoms had resolved by October 30, 2008.

Dr. Fall testified that Dr. Ryan's range of motion measurements on lumbar extension likely are problematic, especially when compared to her findings on October 24, 2008:

[W]hen I saw her, she was able to touch the ground with her hands. So there is a difference there that should be accounted for.

Dr. Striplin further testified that, while claimant has abnormal motion in the cervical and lumbar regions of her spine, she has no impairment of those regions under the AMA Guides. Dr. Striplin explained:

[I]n order to assign impairment for motion loss you have to be able to define the condition that is producing that motion loss. And **since [claimant] has no objectively definable abnormality, there's no** mechanism by which you can incorporate what appears to be motion loss into an **impairment rating**. (Emphasis added).

The findings of both Dr. Fall and Dr. Striplin that claimant is a poor historian is persuasive and is supported by inconsistent stories claimant told to various treating providers and to Dr. Ryan. The Judge credits Dr. Fall's testimony in finding the following: As of October 24, 2008, claimant reported her neck pain had resolved and that she had some residual soreness in her left lower back. In contrast, claimant told Dr. Ryan she had neck pain, which he described as recurrent neck pain. Whereas claimant reported to Dr. Fall that she had no symptoms for a couple of days following the June 3, 2008, MVA, claimant stated in her answers to interrogatories that she had immediate headache symptoms and was off work for 2 weeks. Claimant however lost no time from work until July 21, 2008, after the July 11th MVA. The history claimant gave Dr. Striplin likewise was inconsistent with what she reported to Dr. Fall. The Judge finds it more probably true that claimant is an unreliable historian regarding her medical condition.

Respondents showed it highly probable that Dr. Ryan erred in determining that claimant has not reached MMI because she needs additional acupuncture treatment. The Judge found it more probably true that claimant is an unreliable historian regarding her medical condition. Dr. Ryan's recommendation for acupuncture treatment mirrors Dr. Boulder's recommendation for *Grover*-type medical care to maintain MMI. Dr. Fall disagrees with Dr. Ryan's determination that claimant needs additional acupuncture treatment in order to reach MMI. Dr. Fall persuasively testified that such treatment is not new treatment and is unlikely to change claimant's underlying condition or her overall impairment. Dr. Fall and Dr. Striplin agree that acupuncture treatment recommended by Dr. Ryan will only prevent deterioration and maintain claimant's condition at MMI, but is unlikely to improve that condition. The Judge thus credits the medical opinions and testimony of Dr. Fall and Dr. Striplin in finding it highly probable that Dr. Ryan's determination that claimant has not reached MMI is incorrect.

Respondents showed it highly probable that Dr. Ryan erred in determining that claimant sustained permanent medical impairment according to the AMA Guides and the Workers' Compensation Act. The Judge credits the medical opinion of Dr. Fall in finding that Dr. Ryan's diagnosis of mechanical pain in the lumbar and cervical regions of her spine is nothing more than a finding that claimant complained of pain in those regions. Because the Judge found it more probably true that claimant is an unreliable historian regarding her medical condition, Dr. Ryan's diagnosis based upon those subjective complaints is unreliable. The Judge credited the medical opinions of Dr. Fall and Dr.

Striplin in finding that the absence of physiologic correlation with claimant's complaints fails to support a diagnosis-based impairment under the Workers' Compensation Act or under Table 53 of the AMA Guides. The Judge further credited the medical opinions of Dr. Fall and Dr. Striplin in finding that claimant's symptoms resolved short of the 6-month period of time required for a specific diagnosis under Table 53. . And the Judge credited the medical opinions of Dr. Fall and Dr. Striplin in finding that claimant's MRI studies were clinically insignificant to support a definable medical condition or diagnosis for a Table 53 rating.

Respondents showed it more probably true that the determination of Dr. Boulder, Dr. Fall, and Dr. Stiplin that claimant sustained 0% permanent medical impairment. The Judge credited the medical opinion of Dr. Fall and Dr. Striplin in finding it more probably true that claimant sustained no permanent medical impairment according to the AMA Guides.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Respondents argue they have overcome Dr. Ryan's determination of MMI and permanent medical impairment by clear and convincing evidence. The Judge agrees.

The purpose of the Workers' Compensation Act is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Sections 8-42-107(8)(b)(III) and (c), *supra*, provide that the determination of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, *supra*. A mere difference of opinion between physicians fails to constitute error. *See, Gonzales v. Browning Ferris Indust. of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000). The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998).

The DIME physician's finding under §8-42-107(8)(c), *supra*, is generally the impairment rating. *DeLeon v. Whole Foods Market, Inc.*, W.C. No. 4-600-477 (ICAO November 16, 2006). Once a party sustains the initial burden of overcoming the DIME physician's impairment rating by clear and convincing evidence, the ALJ's determination of the correct rating is then a matter of fact based upon the lesser burden of a preponderance of the evidence. *DeLeon v. Whole Foods Market, Inc.*, *supra*. The ALJ is not required to dissect the overall impairment rating into its component parts and determine whether each part has been overcome by clear and convincing evidence. *DeLeon v. Whole Foods Market, Inc.*, *supra*.

Here, the Judge found that respondents showed it highly probable that Dr. Ryan erred in determining that claimant had not reached MMI and that she sustained permanent medical impairment. Respondents thus overcame Dr. Ryan's determination of MMI and permanent medical impairment by clear and convincing evidence.

As found, claimant showed herself an unreliable historian regarding her medical condition. This finding undermines Dr. Ryan's determination of MMI because he relied upon claimant's report of her symptoms. Dr. Ryan's recommendation for additional acupuncture treatment mirrored Dr. Boulder's recommendation for *Grover*-type medical care to maintain MMI, and not to improve claimant's condition to the point of MMI. The Judge credited Dr. Fall's opinion, wherein she disagreed with Dr. Ryan's determination that claimant needs additional acupuncture treatment in order to reach MMI. The Judge further credited Dr. Fall's opinion in finding such treatment unlikely to change claimant's underlying condition or her overall impairment. The Judge credited the opinions of Dr. Fall and Dr. Striplin in finding that acupuncture treatment recommended by Dr. Ryan will only prevent deterioration and maintain claimant's condition at MMI, but is unlikely to improve that condition.

The Judge further credited the medical opinion of Dr. Fall in finding that Dr. Ryan's diagnosis of mechanical pain in the lumbar and cervical regions of her spine is nothing more than a finding that claimant complained of pain in those regions. Because

the Judge found it more probably true that claimant is an unreliable historian regarding her medical condition, Dr. Ryan's diagnosis based upon those subjective complaints is unreliable. The Judge credited the medical opinions of Dr. Fall and Dr. Striplin in finding that the absence of physiologic correlation with claimant's complaints fails to support a diagnosis-based impairment under the Workers' Compensation Act or under Table 53 of the AMA Guides. The Judge further credited the medical opinions of Dr. Fall and Dr. Striplin in finding that claimant's symptoms resolved short of the 6-month period of time required for a specific diagnosis under Table 53. And the Judge credited the medical opinions of Dr. Fall and Dr. Striplin in finding that claimant's MRI studies were clinically insignificant and failed to support a definable medical condition or diagnosis for a Table 53 rating.

Finally, the Judge found respondents showed it more probably true that that claimant sustained 0% permanent medical impairment. The Judge concludes claimant reached MMI on October 30, 2008. Claimant's request for PPD benefits should be denied and dismissed.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant reached MMI on October 30, 2008, for her injury from the MVAs.

2. Claimant's request for PPD benefits is denied and dismissed.

3. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _October 22, 2009_

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-783-805

ISSUES

The issues for determination are responsibility for termination and temporary total disability benefits from December 3, 2008, to May 18, 2009. The parties stipulated to an average weekly wage of $494.00.

FINDINGS OF FACT

1. Insurer has admitted liability for an injury that occurred on November 20, 2008.

2. On November 26, 2008, a nurse saw Claimant at Employer's clinic. Claimant stated that his job hurt his shoulder and wrist. He asked for a transfer to a different job. He was given an ice massage and returned to work.

3. Claimant was seen at Employer's clinic again on November 28, 2008. He stated that he had used ice the day before and that he would try to get HR to see about a different job. He received an ice massage to his left shoulder. He returned to regular work.

4. Claimant was seen at Employer's clinic again on November 29, 2008. He received an ice massage. He returned to regular work.

5. Claimant did not work on December 1, 2008, due to pain.

6. Claimant spoke to Weimer on December 2, 2008. Weimer is a training manager for Employer. Claimant told Weimer that he was quitting his employment because of his shoulder pain. Weimer sent Claimant to Employer's clinic.

7. Claimant was seen at Employer's clinic again on December 2, 2008. Claimant had left scapula pain with swelling. He received an ice massage and was directed to return to work.

8. Claimant quit his employment on December 2, 2008. He quit his employment because he was unable to perform the duties of his employment without significant pain. Employer had not modified the duties of his employment or assigned him to different duties. Employer had a bid system for different jobs that was based on seniority. Claimant did not attempt to use the bid system to obtain a different job with Employer.

9. Employer referred Claimant to Robert Thiel, M.D. Claimant was examined by Dr. Thiel on December 11, 2008. Dr. Thiel restricted Claimant from lifting, pushing, or pulling over ten pounds and from any work at or above shoulder level. These restrictions of Dr. Thiel are credible and persuasive.

10. Claimant could not perform the usual duties of his employment within the restrictions of Dr. Thiel. Claimant's condition did not worsen between the time he last worked for Employer and the time the restrictions were imposed by Dr. Thiel. Claimant should not have been performing the duties of his employment at the time he quit his employment.

11. Lawrence Lesnak, D.O., examined Claimant on January 30, 2009, and February 11, 2009. Dr. Lesnak restricted Claimant from pulling objects towards his body on a repetitive basis or pulling objects weighing more than twenty pounds and no frequent shoulder level or overhead use of his upper extremity. Claimant could not perform the usual duties of his employment within these restrictions.

12. Claimant located other employment on March 15, 2009. He performed the full duties of his job, and had no wage loss during the time he worked this other job. Claimant worked this other job until April 15, 2009.

13. Dr. Lesnak examined Claimant on April 14, 2009. Dr. Lesnak noted that Claimant was working full time without restrictions. Dr. Lesnak placed Claimant at maximum medical improvement on May 18, 2009. He imposed no restrictions on Claimant.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S.

2. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

3. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo.App. 2000).

4. Claimant has established by a preponderance of the evidence that he was not able to perform the duties of his employment when he quit his employment on December 3, 2008. Claimant was disabled as a result of his compensable injury. Section 8-42-103(1), C.R.S. Claimant was temporarily and totally disabled as of December 3, 2008. Section 8-42-105(1), C.R.S.

5. Claimant quit his employment because he was no longer able to perform the duties of his employment due to his compensable injury. Claimant's employment was terminated due to his injury. Claimant was not responsible for the termination of his employment for Employer. Sections 8-42-103(g) and 8-42-105(4), C.R.S., do not apply. Therefore, Claimant need not show a worsening of condition after the termination of his employment in order to receive temporary disability benefits. *See Longmont Toyota v. Anderson Toyota, Inc.*, 102 P.3d 323 (Colo. 2004).

6. Insurer is liable for temporary total disability benefits commencing December 3, 2008. Temporary total disability benefits are payable at the rate of two-thirds of Claimant's average weekly wage. Section 8-42-105(1), C.R.S. The parties have stipulated to an average weekly wage of $494.00. Temporary total disability benefits are payable at the rate of $329.33 per week. Insurer is liable for interest at the rate of eight percent per annum on all benefits not paid when due. Section 8-43-410, C.R.S.

7. Temporary total disability benefits end when a claimant returns to regular employment. Section 8-42-105(3)(b), C.R.S. Claimant located and began other employment on March 15, 2009. Claimant performed the full duties of this other employment and had no wage loss. Temporary disability benefits end on March 14, 2009.

8. Claimant lost his other employment on April 15, 2009. At the time he lost his other employment he was under no restrictions and was capable of performing the job he had lost and the job he was performing at the time of this compensable injury. Claimant has not shown that he was disabled after April 15, 2009. Claimant is not entitled to temporary disability benefits after his temporary disability ended after March 14, 2009.

ORDER

It is therefore ordered that Insurer shall pay Claimant temporary total disability benefits from December 3, 2008, through March 14, 2009, at the rate of $329.33 per week. Insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: *October 22, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-720-727

ISSUES

¬ Did claimant prove by a preponderance of the evidence that employer should be penalized under §8-43-408(4) for failure to comply with a lawful order?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

On June 3, 2009, claimant and employer appeared for hearing before Administrative Law Judge Barbara S. Henk. At the time of that hearing, employer was represented by Jennifer Kroell, Esq. At the hearing before Judge Henk, the parties agreed to have Judge Henk reinstate a prior Summary Order entered by Administrative Law Judge Bruce C. Friend on March 2, 2009. Judge Henk entered her Summary Order, dated June 25, 2009, incorporating and adopting the findings of Judge Friend. Employer failed to request specific findings of fact and failed to file any petition to review Judge Henk's Summary Order. Judge Henk's Summary Order is a final order pursuant to §§8-43-215(1) and 8-43-301(1), *supra*.

In her Summary Order, Judge Henk found that claimant was injured in the course and scope of her employment while working for employer on February 5, 2007.

In her Summary Order, Judge Henk found that claimant received medical care from Muyoung Ho Kim, M.D., Presb/St. Luke Hospital, Metro Denver Anesthesia, Robert E. Tuchler, M.D., and the Center for Hand Rehabilitation. Judge Henk found that the care claimant received from these providers was reasonably needed to cure and relieve the effects of claimant's compensable injury. Judge Henk ordered employer to pay bills from these providers totaling $13,171.35.

In her Summary Order, Judge Henk found that claimant's average weekly wage is $342.00 and that her temporary total disability (TTD) benefits are payable at the rate of $228.00 per week. Judge Henk found claimant entitled to TTD benefits for a period of 57.71 weeks from February 5, 2007, to March 15, 2008. Judge Henk found employer liable to claimant for past TTD benefits in the amount of $13,158.86, which were due her from February 5, 2007, to March 15, 2008. Judge Henk found that employer failed to carry worker's compensation insurance on the date of claimant's injury and increased

employer's liability for compensation benefits by fifty percent (50%), pursuant to §8-43-408(1), *supra*.

In her Summary Order, Judge Henk found employer liable to claimant in the amount of $19,738.29 for combined non-insurance penalty and TTD benefits. Judge Henk found that employer's liability insurer paid claimant $5,000.00, which Judge Henk credited against employer's liability to pay the $19,738.29. Judge Henk thus ordered employer to pay claimant a lump sum of $14,738.29 for TTD benefits and penalty for failure to insure.

In her Summary Order, Judge Henk found claimant sustained a serious permanent disfigurement to the back of both hands and ordered employer to pay additional compensation for that disfigurement in the amount of $2,000.00 pursuant to §8-42-108, *supra*.

In her Summary Order, Judge Henk ordered the following pursuant to §8-43-408(2), *supra*: "[I]n lieu of payment of the compensation and benefits to claimant, employer shall:

a. Deposit the sum of $30,000.00 with the Division of Workers' Compensation, as trustee, within ten days of this order, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to and sent to Subsequent Injury Fund; Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009; or

b. File a bond in the sum of $30,000.00 with the Division of Workers' Compensation within ten (10) days of the date of this order:

(1) Signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation; or

(2) Issued by a surety company authorized to do business in Colorado.

The bond shall guarantee payment of the compensation and benefits awarded.

c. Employer shall notify the Division of Workers' Compensation of payments made pursuant to this order."

In her Summary Order, Judge Henk admonished employer that, should employer fail to comply with the Summary Order by paying the amounts due, by depositing the funds with the Division, or by posting a bond, employer could be liable for an additional fifty percent penalty of the amount due, plus and reasonable attorney fees, pursuant to §8-43-408(4), *supra*.

Crediting claimant's testimony, the Judge finds that claimant confirmed with the Division of Workers' Compensation that employer: (a) Failed to pay the amounts due to claimant; (2) failed to deposit $30,000.00 in funds with the Division; and (3) failed to post a bond in the amount of $30,000.00. The Judge thus finds employer failed to comply with the lawful Summary Order of Judge Henk.

The Judge finds employer liable to claimant for a 50% penalty in the amount of $15,000.00 (50% of the $30,000.00) pursuant to §8-43-408(4), *supra*, for failure to comply with the Summary Order of Judge Henk.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Claimant argues she has proven by a preponderance of the evidence that employer should be penalized under §8-43-408(4) for failure to comply the lawful Summary Order of Judge Henk. The Judge agrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

Section 8-43-408(2), *supra*, mandated Judge Henk to compute claimant's unpaid benefits and compensation and to require employer to pay that amount the Division as trustee or to file a bond. Judge Henk computed claimant's unpaid benefits and compensation at $30,000.00. Judge Henk ordered employer to pay $30,000.00 to the Division as trustee or to file with the Division a bond securing that payment. As found, employer failed to comply with Judge Henk's Summary Order.

Section 8-43-408(4), *supra*, provides a penalty in the amount of 50% where employer failed to comply with Judge Henk's Summary Order. The Judge thus found employer liable to claimant for a 50% penalty in the amount of $15,000.00 (50% of the $30,000.00) pursuant to §8-43-408(4), *supra*, for failure to comply with the Summary Order of Judge Henk.

The Judge concludes that, in addition to the $30,000.00 employer owes under the Summary Order of Judge Henk, employer should pay claimant a penalty in the amount of $15,000.00.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Employer shall pay claimant a penalty in the amount of $15,000.00, which is in addition to the $30,000.00 that Judge Henk ordered employer to pay claimant under the Summary Order.

2. Employer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

3. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _October 23, 2009__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-781-078

ISSUES

Whether Claimant sustained a compensable injury from exposure to toxoplasmosis parasite arising out of and in the course of her employment with Employer in July and August 2008 when she was assigned to a crew cleaning a home in which cats were present.

If compensable, the remaining issues were determination of Claimant's average weekly wage; entitlement to temporary total disability benefits beginning November 24, 2008; medical benefits, reasonableness and necessity and determination of the authorized treating physician(s).

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

Claimant began working for Employer as a house cleaner on July 16, 2008. Employer's business involves, in part, cleaning the residential homes of private clients. Claimant was part of a crew assigned to clean the house of Diana Struve, a homeowner who had three cats.

1. On July 18, 2008 and August 15, 2008 Claimant worked as a house cleaner for Employer at the home of S along with her supervisor, Velasco. The cleaning duties included dusting, vacuuming rooms, cleaning a bathroom, vacuuming leaves in the atrium, and cleaning the kitchen. Claimant did not clean the cat litter box nor as she ever asked to do so. Claimant did not see any cat feces outside of the litter box, nor did she come into contact in any way with cat feces while cleaning Ms. S's home on either

July 18, 2008 or August 15, 2008. Claimant did not eat cat feces at Ms. S's home or at any other time.

2. On August 4, 2009, S testified via evidentiary deposition. Ms S's testimony is credible and persuasive. Ms. S in the year 2008 she had only 3 cats never had more than 3 cats. Ms. S's cats were indoor cats and she never let them out of her house. One of her cats, Big Blackie, died and was tested for toxoplasmosis by veterinarian, Dr. Allen Hayes, at the request of Ms. S. Ms. S cleaned her cats' litter box on a daily basis.

3. On November 25, 2008 Claimant presented to Longmont United Hospital where she came under the care of Douglas Tangel, M.D. Claimant reported a two day history of left-sided flank pain. Dr. Tangel admitted Claimant for medications and further workup.

4. On November 26, 2008, Claimant underwent surgery by Alexander Mason, M.D. for examination and biopsy of a lesion on Claimant's thoracic spine at T5. The pathology report from the same day noted that the "Findings in this case are diagnostic of toxoplasmosis".

5. On December 8, 2008 Dr. Parvot at Longmont United Hospital provided a hand-written note on a prescription form in which it was noted that Claimant had a diagnosis of CNS toxoplasmosis that is "caused by a parasite typically encountered in cat feces." On December 22, 2008, on a prescription pad with Dr. Tangel's name noted at the top in a hand-written note signed by Dr. Tangel, the diagnosis of toxoplasmosis is noted as being "from exposure to cats at work." There is no discussion in wither of these the hand-written notes regarding the basis for the opinions, analysis of causation, and no documentation of what information the physicians were relying upon in forming their opinions. The opinions of Dr. Parvot and Dr. Tangel are not credible and persuasive to establish that Claimant was exposed to toxoplasmosis in the home of S or that Claimant's medical condition was causally related to such an exposure.

6. On September 21, 2009, Dr. Allen R. Hayes, DVM, testified via evidentiary deposition. Dr. Hayes is an expert in general veterinary medicine. Dr. Hayes's testimony is found to be credible and persuasive. Dr. Hayes tested one of Ms. S's cats, Big Blackie, for toxoplasmosis and the test was negative for the presence of toxoplasmosis in this cat. Dr. Hayes testified, and it is found, that since Big Blackie had tested negative for toxoplasmsis Big Blackie could not have passed on the toxoplasmosis oocyst to humans.

7. Respondents retained board certified veterinary internist and expert in infectious diseases, John E. Stein, Jr., D.V.M., to perform an independent veterinary medical review focused on a causation analysis of toxoplasmosis in this case. Dr. Stein was qualified at hearing as an expert in veterinary medicine involving parasites and infectious diseases. Dr. Stein testified at hearing, and it is found, that Claimant "very likely did not contract CNS Toxoplasmosis from exposure to cats at the home of Ms. S as Ms. Maturin has claimed. It is much more likely, and scientifically probable, that Ms. Maturin

contracted CNS Toxoplasmosis from exposure to and ingestion of uncooked meats and/or vegetables that were not properly washed". Dr. Stein opined that it was "extremely" unlikely that Claimant contracted CNS Toxoplasmosis from exposure to cats in S's home. The opinions expressed by Dr. Stein in his written report and his testimony at hearing are found to be credible, persuasive and are found as fact.

8. Respondents also retained board certified internal medicine and occupational medicine physician Annu Ramaswamy, M.D. to perform an independent medical examination focused on a causation analysis. Dr. Ramaswamy was qualified at hearing as an expert in Internal and Occupational medicine.

9. In his written report, Dr. Ramaswamy discussed *Toxoplasmosis* generally, and causation specifically with respect to its transmission to humans. Dr. Ramaswamy also discussed a latent stage of infection in which the parasite can remain dormant and can later reactivate. At hearing, Dr. Ramaswamy credibly testified that the latency period can last for many years and even decades. As such, an individual can be exposed to the parasite but only reactivate, or show symptoms many years or even decades later. Dr. Ramaswamy opined that transmission of the parasite to humans "typically occurs through the ingestion of raw or undercooked meat (pork, lamb) that contains tissue cysts" and "through the ingestion of vegetables, water or food that is contaminated with oocysts." Dr. Ramaswamy further listed several less common routes of transmission including that of cats. Dr. Ramaswamy opined that, "The major source of injection in humans in the United States is through the ingestion of tissue cysts in infected meat (primarily pork and lamb)."

10. In forming his opinions, Dr. Ramaswamy referenced a text, Principles and Practice of Infectious Diseases (6th edition) by Mandell, Douglas, and Bennett (2005; volume 2; chapter 276; pages 3170-3198) that he consulted in researching the causation issues in this matter. Dr. Ramaswamy quoted in his report from the text, which provided in pertinent part, as follows: (italics added)

When considering Toxoplasmosis and the differential diagnosis of the patient's illness, emphasis should not be placed on whether the patient has been exposed to cats. Transmission of oocysts virtually always occurs without knowledge of the patient and may be unrelated to direct exposure to a cat (for example, transmission by contaminated vegetables or water.) Patients with an indoor cat or cats that are fed only cooked food are not at risk of acquiring the infection from the cat.

11. Dr. Ramaswamy testified at hearing and documented in his report the "cascade of events" that must occur in order to presume transmission of toxoplasmosis from a cat to Claimant. First, one of Ms. S's cats would have to ingest an animal infected with Toxoplasmosis. Second, one would have to assume that the cat had never been infected prior to that time in its life. In effect, it must be a first-time exposure for the cat. Third, within a couple of weeks the cat would have to shed the oocysts in its feces. Fourth, a minimum of 24 hours would have to pass before the oocysts would become infectious. Fifth, Claimant would then have to orally ingest, eat, the infected cat feces

within a 24-hour period. Dr. Ramaswamy stated that if the litter box was changed on a daily basis, the cleaning would significantly decrease the risk of exposure to Toxoplasmosis. Dr. Ramaswamy concluded in his report and in his hearing testimony that, "The odds of all of these events occurring, in total, would be extremely slim, at best" and "highly improbable." The ALJ finds Dr. Ramaswamy's opinions to be credible, persuasive and they are found as fact. Dr. Ramaswany's opinions are amply supported by the medical literature upon which he consulted and the concurring opinions of Dr. Stein.

12. The opinions and testimony of Dr. Stein and Dr. Ramaswamy are found to be more credible and persuasive than the opinions expressed by Dr. Parvot and Dr. Tangel.

13. Claimant has failed to prove, by a preponderance of the evidence, that she sustained a compensable injury from contracting toxoplasmosis due to exposure to cats while cleaning the home of S on July 18 and August 15, 2008 arising out of and in the course of her employment with Employer.

CONCLUSIONS OF LAW

15. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

16. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

17. Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded. Section 8-41-301(1)(c), C.R.S.; *Faulkner v. Indus. Claim Appeals Office*, 12 P3d 844, 846 (Colo. App. 2000).

18. The evidence must establish the causal connection with reasonable probability, not medical certainty. *Ringsby Truck Lines, Inc. v. Industrial Commission, 491 P.2d 106 (Colo. App. 1971)*. Reasonable probability exists if the proposition is supported by substantial evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding. *F.R. Orr Construction v. Rinta, 717 P.2d 965 (Colo. App. 1985)*. An award of benefits may not be based upon or denied upon speculation or conjecture. *Deines Bros. v. Indus. Comm'n,* 125 Colo. 258, 242 P.2d 600 (1952); *Indus. Comm'n v. Havens,* 136 Colo. 111, 134 P.2d 698 (1957).

19. An occupational disease is "a disease which results directly from the employment or conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard which the worker would have been equally exposed outside of the employment." Section 8-40-201(14), C.R.S.

20. A claimant is entitled to recovery for an occupational disease injury only if the hazards of employment cause, intensify or aggravate – to some degree – the disability for which compensation is sought. *Anderson v. Brinkhoff*, 839 P.2d 819, 824 (Colo. 1993). Where the disease for which a claimant is seeking compensation is produced solely by some extrinsic or independent cause, it is not compensable. *Id.* At 824. Further, where an occupational exposure is not a "necessary precondition" to the development of the disease, a claimant sustains an occupational disease only to the extent that the conditions of the employment contributed to the disability. *Id*. At 824; *Masdin v. Gardner-Denver-Cooper Indus.*, 689 P2d 714, 717 (Colo.App. 1984). The purpose of this rule "is to ensure that the disease results from the claimant's occupational exposure to hazards of the disease and not hazards which the claimant is equally exposed to outside of employment." *Saenz-Rico v. Yellow Freight System, Inc.*, W.C. No. 4-320-928 (January 20, 1998); *see also Stewart v. Dillon Co.*, W.C. No. 4-257-450 (November 20, 1996).

21. In this case, Claimant's claim for compensation is based upon an alleged exposure to cat feces containing the toxoplasmosis parasite on July 18, 2008 and August 15, 2008, while working for the Employer at the home of S. In order to prevail in her claim for compensation, two questions must be answered in favor of Claimant. First, Claimant must prove that she was exposed to, as a hazard of her employment, and ingested cat feces containing toxoplasmosis parasite while working for Employer in the home of S on July 18, 2008 and August 15, 2008. If Claimant proves that she was exposed to, and ingested, cat feces containing toxoplasmosis in the home of S on July 18, 2008 and August 15, 2008 then the issue of causation of Claimant's toxoplasmosis tumor must be addressed. It is Claimant's burden to prove first an exposure at work to cat feces containing toxoplasmosis, and, if so, then to prove a causal link between her exposure and the diagnosis of toxoplasmosis resulting in the need for medical treatment and disability.

22. In this case, Claimant failed to prove by a preponderance of the credible and persuasive evidence that she was exposed to cat feces containing the toxoplasmosis parasite while at work in the home of S on July 18, 2008 and August 15, 2008. Claimant failed to present persuasive evidence that toxoplasmosis existed in the home of S on the dates alleged. The persuasive evidence showed that one of three of Ms. S's cats tested negative for toxoplasmosis, and, accordingly, could not have transmitted the parasite to Claimant. Claimant further failed to prove that either of the other two cats had toxoplasmosis. While it may be correct, as Claimant contends, that 30% of cats carry the toxoplamosis parasite, this fails to establish that it was more likely than not that the cats present in the S home on the two occasions when Claimant cleaned the home were infected with the toxoplamosis parasite. The same can be said of the evidence from Mayra Salazar and Claimant that the home 'smelled very badly of the dirtiness of cats'. There was also no persuasive evidence that any of Ms. S's cats was shedding the toxoplasmosis parasite in their feces or that the parasite was contagious to humans during the two days that Claimant was present in the home of S. Further, Claimant did not see any cat feces on either day, and she did not come into contact with nor did she ingest any cat feces on either day. Considering the evidence as a whole, to find and conclude in favor of Claimant's allegation that she was exposed to cat feces containing the toxoplasmosis parasite while at work for Employer in the home of S on July 18, 2008 and August 15, 2008 would require the ALJ to impermissibly engage in speculation and conjecture. The ALJ declines to do this.

23. The ALJ further concludes that a finding that Claimant has failed to prove that she sustained a compensable injury from exposure to cats in the S home is supported by the credible and persuasive opinions and testimony of Dr. Stein and Dr. Ramaswamy.

ORDER

It is therefore ordered that:

Claimant's claim for compensation and benefits, including Claimant's claims for medical benefits and temporary total benefits, is DENIED and DISMISSED, in their entirety.

DATED: October 26, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-734-420

ISSUE

Whether Claimant has made a proper showing that she is entitled to a change of physician pursuant to §8-43-404(5), C.R.S.

FINDINGS OF FACT

1. Claimant worked for Employer as a janitor. On August 30, 2007 she injured her neck and upper shoulder area while moving portable bleachers.

2. Claimant received Temporary Total Disability (TTD) benefits for various periods of time between August 31, 2007 and August 14, 2008.

3. Claimant obtained medical treatment from Authorized Treating Physician (ATP) Annu Ramaswamy, M.D. On September 29, 2008 Dr. Ramaswamy determined that Claimant had reached Maximum Medical Improvement (MMI). He concluded that Claimant had suffered an 8% cervical spine impairment as a result of her industrial injuries.

4. Dr. Ramaswamy's medical records reveal that Claimant received some medical maintenance treatment subsequent to reaching MMI. However, medical records reflect that by March 9, 2009 Claimant had completed all appropriate medical maintenance treatment.

5. On February 5, 2009 Gareth E. Shemesh, M.D. conducted a Division Independent Medical Examination (DIME) of Claimant. Dr. Shemesh agreed with Dr. Ramaswamy's MMI determination and concluded that Claimant had suffered a 14% whole person impairment rating. The impairment rating was based upon diagnoses of a cervical strain and right occipital neuralgia.

6. Dr. Shemesh specifically determined that Claimant did not require additional medical maintenance treatment. He instead directed Claimant to continue with her active, independent home exercise program and over-the-counter anti-inflammatory medications. Dr. Shemesh explained that Claimant "has already undergone comprehensive treatment for her injuries, as well as a comprehensive diagnostic work-up. It is unlikely that additional treatment will provide the patient with any appreciable improvement in her persistent symptoms."

7. On May 1, 2009 Respondents filed a Final Admission of Liability (FAL) consistent with Dr. Shemesh's DIME determination. The FAL denied liability for medical maintenance benefits. Claimant objected to the FAL and requested a hearing.

8. Claimant testified at the hearing in this matter. She explained that she sustained a stomach injury on April 12, 2007 and was directed to Dr. Ramaswamy for treatment. She remarked that he diagnosed her with nerve pain but did not improve her condition. Claimant explained that she had no trust and confidence in Dr. Ramaswamy because he did not believe her or seriously consider her complaints. She thus obtained additional medical treatment from Kaiser Permanente. Claimant noted that when Employer directed her to Dr. Ramaswamy in the present matter their relationship improved.

However, he did not take the time to answer her questions. She also commented that Dr. Ramaswamy did not seem to have time to evaluate her and only examined her for approximately five minutes at medical appointments. Claimant thus requested a change of physician to David Reinhard, M.D.

9. Before Claimant can establish that she is entitled to a change of physician, she must first demonstrate that she requires medical maintenance benefits. However, Claimant has failed to present substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of her industrial injuries or prevent further deterioration of her condition. In a March 9, 2009 medical report ATP Dr. Ramaswamy noted that Claimant had completed all appropriate medical maintenance treatment. DIME physician Dr. Shemesh also determined that Claimant did not require additional medical maintenance treatment and instead directed Claimant to continue with her independent home exercise program and over-the-counter anti-inflammatory medications.

10. Claimant has also failed to make a proper showing that she is entitled to a change of physician. Claimant testified that Dr. Ramaswamy did not seem to have time to evaluate her and only examined her for approximately five minutes at medical appointments. However, a change of physician is not required simply because Claimant may have expressed dissatisfaction with Dr. Ramaswamy or would prefer to receive treatment from a doctor of her choosing. Because the record reveals that Claimant received adequate medical treatment she is not entitled to a change of physician.

CONCLUSIONS OF LAW

1. The purpose of the “Workers’ Compensation Act of Colorado” (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge’s factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and ac-

tions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Section 8-43-404(5)(a), C.R.S. permits the employer or insurer to select the treating physician in the first instance. Once the respondents have exercised their right to select the treating physician, the claimant may not change the physician without the insurer's permission or "upon the proper showing to the division." §8-43-404(5)(a), C.R.S.; *In Re Tovar,* W.C. No. 4-597-412 (ICAP, July 24, 2008). Because §8-43-404(5)(a), C.R.S. does not define "proper showing" the ALJ has discretionary authority to determine whether the circumstances warrant a change of physician. *Jones v. T.T.C. Illinois, Inc.,* W.C. No. 4-503-150 (ICAP, May 5, 2006).

5. The ALJ's decision regarding a change of physician should consider the claimant's need for reasonable and necessary medical treatment while protecting the respondent's interest in being apprised of the course of treatment for which it may ultimately be liable. *Id.* The ALJ may consider whether the claimant and physician were unable to communicate such that the physician's treatment failed to prove effective in relieving the claimant from the effects of the industrial injury. *See Merrill v. Mulberry Inn, Inc.,* W.C. No. 3-949-781 (ICAP, Nov. 16, 1995). However, a change of physician is not required merely because a claimant expresses dissatisfaction with the designated treating physician or would simply prefer to receive treatment from a doctor of her choosing. *In Re Hoefner,* W.C. No. 4-541-518 (ICAP, June 2, 2003). Finally, where an employee has been receiving adequate medical treatment, courts need not permit a change of physician. *See Greenwalt-Beltmain v. Dep't of Regulatory Agencies,* W.C. No. 3-896-932 (ICAP, Dec. 5, 1995); *Zimmerman v. United Parcel Service,* W.C. No. 4-018-264 (ICAP, Aug. 23, 1995).

6. To prove entitlement to medical maintenance benefits, a claimant must present substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of the industrial injury or prevent further deterioration of her condition. *Grover v. Industrial Comm'n.,* 759 P.2d 705, 710-13 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609, 611 (Colo. App. 1995). Once a claimant establishes the probable need for future medical treatment she "is entitled to a general award of future medical benefits, subject to the employer's right to contest compensability, reasonableness, or necessity." *Hanna v. Print Expediters, Inc.*, 77 P.3d 863, 866 (Colo. App. 2003); *see Karathanasis v. Chilis Grill & Bar,* W.C. No. 4-461-989 (ICAP, Aug. 8, 2003). Whether a claimant has presented substantial evidence justifying an award of *Grover* medical benefits is one of fact for determination by the Judge. *Holly Nursing Care Center v. Industrial Claim Appeals Office,* 919 P.2d 701, 704 (Colo. App. 1999).

7. As found, before Claimant can establish that she is entitled to a change of physician, she must first demonstrate that she requires medical maintenance benefits. However, Claimant has failed to present substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of her

industrial injuries or prevent further deterioration of her condition. In a March 9, 2009 medical report ATP Dr. Ramaswamy noted that Claimant had completed all appropriate medical maintenance treatment. DIME physician Dr. Shemesh also determined that Claimant did not require additional medical maintenance treatment and instead directed Claimant to continue with her independent home exercise program and over-the-counter anti-inflammatory medications.

8. As found, Claimant has also failed to make a proper showing that she is entitled to a change of physician. Claimant testified that Dr. Ramaswamy did not seem to have time to evaluate her and only examined her for approximately five minutes at medical appointments. However, a change of physician is not required simply because Claimant may have expressed dissatisfaction with Dr. Ramaswamy or would prefer to receive treatment from a doctor of her choosing. Because the record reveals that Claimant received adequate medical treatment she is not entitled to a change of physician.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's request for a change of physician to Dr. Reinhard is denied.

2. Any issues not resolved by this Order are reserved for future determination.

DATED: October 23, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-789-168

ISSUES

- Whether Claimant sustained a compensable occupational disease;
- Whether Claimant is entitled to medical benefits to treat the occupational disease;
- Whether Claimant's treatment providers at Kaiser Permanente, and referrals by them, are authorized; and
- The parties stipulated that Claimant's average weekly wage is $1,149.68.

FINDINGS OF FACT

1. Claimant has worked as both a 911 and police dispatcher for the Respondent for approximately 18 years.

2. Claimant's job duties include operating and monitoring communications equipment in response to police emergencies; controlling the movement of police patrol units; providing response to public safety emergencies; communicating and coordinating activity between other agencies and police officers; obtaining data and maintaining records.

3. To perform these job duties, Claimant used a headset, a mouse and keyboard, a telephone, several monitors, an adjustable chair and a workstation with a hydraulic sit and stand feature. Claimant used the headset to respond to police radios and used the telephone occasionally to place telephone calls. Claimant and other dispatchers often cradled the telephone between their ear and their shoulder if they needed to simultaneously use the keyboard. Such telephone calls were short in duration although the total minutes spent on such calls may equal one hour per shift.

4. Claimant went to the emergency room on June 11, 2008, with complaints of headaches and nausea. Claimant also began leave under the Family Medical Leave Act (FMLA) on the same day.

5. Claimant followed up with her personal physician at Kaiser Permanente on June 13, 2008, and again on June 16, 2008, with complaints of throbbing and dull pain bilaterally in the occipital area and right frontal area. Claimant also reported dizziness, aura, light sensitivity and nausea. His assessment was mixed tension and migraine headaches and he continued Claimant's prescription medications for migraines and tension headaches.

6. Claimant had a telephone appointment on June 19, 2008, with Dr. Burchinal at Kaiser. She reported to him that she had been having headaches for several weeks prior to reporting to the ER on June 11. She also reported neck tension and tightness which she attributed to a lengthy car ride. Dr. Burchinal recommended that Claimant consider massage therapy, chiropractic care or acupuncture to help with the headaches. He noted that the headaches sounded more muscular in origin and prescribed Flexeril for muscle tightness.

7. Claimant returned to Kaiser on July 2, 2008, and reported to Dr. Burchinal that her headaches had improved until she had massage therapy six days earlier. Claimant reported that following the massage, her headaches returned, she could not abduct her right arm due to pain and that she gets lightheaded when she moves too fast and gets pains along the lateral neck up to her ears. Claimant also reported that as soon as she woke up in the morning, her pain would start and that she was not going to work due to her inability to concentrate when her headaches were bad. Dr. Burchinal's examination revealed that Claimant tenderness to palpation at the trapezius, rhomboids, sternomastoids, and levator scapulae. Claimant's range of motion in the neck was full, but painful at all planes and shoulder shrug was painful. Dr. Burchinal assessed headaches due to muscle tightness and right arm "radicular s/s" but with no neurological deficits. The plan was to get an ESR to determine whether the Claimant had myositis in the shoulder muscles, a referral for physical therapy and continued on medications. By this time, Claimant had not worked for 21 days.

8. Claimant returned to work for four days from July 20 through July 23, 2008.

9. Sometime in July 2008, Claimant saw a chiropractor, Dr. Gappa, at her physician's suggestion. Dr. Gappa's treatment notes and records were not offered into evidence. Claimant testified that Dr. Gappa told her that her pain complaints might be

work-related. Claimant reported to a supervisor over the telephone that Dr. Gappa thought her pain complaints might be work related. The supervisor questioned Claimant's reasoning for believing her pain complaints were work-related, but did not refer Claimant to a physician at that time.

10. Dr. Gappa completed a FMLA form on August 4, 2008, which stated that Claimant had a two week disability due to chronic neck pain that will require treatment and that Claimant needed to rest to heal. He indicated that Claimant could not work from July 28 to August 15, 2008. Dr. Gappa did not comment on the work-relatedness of Claimant's symptoms.

11. On August 11, 2008, Claimant returned to Kaiser and saw Dr. Terrence Boland. Claimant reported to Dr. Boland that she had sharp and burning pain in the occipital and posterior cervical area which began radiating down her arms into her first 3 digits with some numbness. Claimant also reported that her headaches usually start in the late afternoon and build in intensity, that she has mild photophobia, phonophobia and nausea with the headaches, that weather changes trigger her headaches and she occasionally has aura. Claimant reported excessive caffeine consumption. Dr. Boland assessed, mixed pattern headaches, question C5 radiculopathy, and caffeine withdrawal headaches. Dr. Boland suggested that Claimant taper off caffeine, continue alternative therapies including massage and chiropractic manipulation, medications and referred Claimant for a cervical spine MRI.

12. On August 22, 2008, Dr. Boland discussed Claimant's MRI results with the Claimant. The MRI revealed some narrowing of the foramina at the spine level C4-5. During that conversation, Claimant reported that she was still having pain, not getting any better and not working because of the pain. Claimant had not worked since July 23.

13. On September 4, 2008, Claimant returned to Dr. Boland and reported that she continued to have daily neck and arm pain with intermittent headaches. Dr. Boland discussed the treatment she received and was concerned about her use of narcotic and sedative medications that did not seem to help her problems. Claimant had been off from work from July 24 through August 30, a period of thirty seven days, and returned to work for four days on August 31, 2008.

14. On September 26, 2008, she saw Dr. Pearson for treatment of a headache that had lasted two days. She had worked eight of the eleven days before this appointment. As with previous medical encounters, Kaiser made various treatment and lifestyle recommendations to improve the headache and neck problems.

15. Dr. Boland called Claimant on October 3, 2008. She reported that the headache that Dr. Pearson treated on September 26, 2008, resolved two days later. She still continued to report neck pain which radiates into her shoulders and described a new problem that consisted of sharp and shooting pain in her legs with a burning discomfort in her feet. Dr. Boland encouraged her to return to work and stated that there was no medical reason why she could not work. He also assessed Claimant with major depression and noted that the depression is probably influencing her chronic pain syndrome. She had been off work for nine days at this time.

16. On October 6, 2008, Claimant saw Dr. Wilson for a cervical epidural steroid injection. Claimant reported to the nurse that shat had pain in her posterior neck, bilateral shoulders, in underarm areas, and down both her arms. She reported that the pain was worse that day on the left side, but it had been worse on the right side the week before.

It was worse with lying down, sitting, or turning her head and was worse in the evening after holding her head up all day. Dr. Wilson gave her an injection at C4-5 and noted that the MRI showed C4-5 foraminal narrowing which he felt was not concordant with Claimant's symptoms. At the time of the October 6, 2008, visit, Claimant had been off from work for eleven consecutive days.

17. Claimant again saw Dr. Boland on October 20, 2008, and complained of burning pain that involved her arms and extended from her neck through her spine and down into her legs and feet, and daily headaches. He diagnosed chronic pain syndrome of undetermined etiology, major depression, chronic family stress, and mixed pattern headaches. He took her off all narcotic medications, recommended counseling for her depression, daily exercise, and other measures. At the time of this appointment, Claimant had been off from work for twenty-five consecutive days.

18. Claimant saw Dr. Deborah Fisher on October 27, 2008, for a neurological evaluation. She continued to complain of headaches that recurred when she was upright as well as upper extremity pain that fluctuated between the left and right arms. Dr. Fisher performed a thorough examination and diagnosed cervicalgia, chronic daily headache with mixed tension and vascular features, obesity, and chronic pain syndrome. Dr. Fisher did not state that any of these problems were work-related. Dr. Fisher prescribed two new medications, Baclofen for neck spasms, and Topomax for the treatment of migraine headaches.

19. None of Claimant's Kaiser providers opined or suggested that Claimant's pain complaints were work-related.

20. Claimant ultimately filed a workers' claim for compensation on March 30, 2009, and a completed an injury report on April 3, 2009. In the injury report, Claimant described her injury as follows, "In June 2008, I started getting headaches and ended up in the emergency room . . . "

21. Respondent referred Claimant to Denver Health for treatment. In her reports to the physicians at Denver Health, Claimant attributed her pain symptoms to work-related ergonomics. Both Drs. Blair and Kuehn released Claimant to work with no restrictions. Neither physician directly opined as to the cause of Claimant's symptoms other than comments regarding Claimant's subjective determination that her symptoms were work-related.

22. On June 8, 2009, Claimant saw Dr. R.J. Swarsen for an independent medical examination. She reported to him that there is no specific date of acute injury, but that it started a year earlier with right upper arm pain. She also reported that in May and June 2008, she started getting headaches. Dr. Swarsen reviewed Claimant's medical records beginning August 2008, but did not review all of the medical records that were offered into evidence. Dr. Swarsen felt that Claimant's headaches were migraine-like rather than true migraine headaches and that Claimant's symptoms were related to her work and long term use of computers, phones and mouse and due to stretching and reaching. Dr. Swarsen's opinions assume that Claimant repetitively reaches with her arms, but no persuasive evidence confirms such assumption. Dr. Swarsen's opinion also assumes that Claimant's symptoms subside when she is not working; however the medical records directly contradict that assumption.

23. Claimant saw Dr. Brian Lambden on July 1, 2009, for an independent medical examination. Dr. Lambden also reviewed medical records beginning in June 2006

through June 8, 2009, and ergonomic evaluations completed by Scott Washam and Margot Burns. Dr. Lambden opined that Claimant suffered from migraine headaches and which are not related to Claimant's job duties. Dr. Lambden's opinions concerning the migraine headaches are supported by the description of her symptoms, which included aura, photophobia and nausea. Dr. Lambden also opined that Claimant's neck pain is multifactoral secondary to underlying degenerative disk disease and perhaps related to the headaches plus myofascial pain. Dr. Lambden explained that Claimant's neck pain is ubiquitous and difficult to relate to any particular activity. Dr. Lambden, however, noted that if Claimant was required to cradle a telephone between her ear and neck for up to an hour per day, it could increase her neck symptoms.

24. Claimant suggested that she cradled the phone between her ear and neck several times each day totaling an hour or more each shift. Assuming Claimant's description of this work activity is accurate, Claimant's first complaints of neck pain to her Kaiser physician occurred after she began a leave of absence under FMLA. Thus, the onset of neck pain after being off work and the continued neck pain while remaining off work do not support Claimant's contention that cradling the phone brought about neck pain.

25. Based on the foregoing, Claimant has not established that she developed an occupational disease to her neck, arms, shoulders, or via headaches.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); CJI, Civil 3:16 (2005).

4. "Occupational disease" is defined by §8-40-201(14), C.R.S., as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

5. This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

6. As a matter of law, medical evidence is not required to establish causation, although it is a factor that may be considered in addressing that determination. See *Savio House v. Dennis,* 665 P.2d 141 (Colo. App. 1983). Further, even uncontroverted medical opinions are not binding on the ALJ. See *Rockwell International v. Turnbull,* 802 P.2d 1182 (Colo. App. 1983).

7. A preexisting condition does not disqualify a claimant from receiving workers' compensation benefits. Rather, where the industrial injury aggravates, accelerates, or combines with a preexisting disease or infirmity to produce the need for treatment, the treatment is a compensable consequence of the industrial injury. *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App.1990).

8. While the Judge has no reason to doubt that Claimant suffers from headaches and other pain symptoms in her neck and shoulders, Claimant has not established that these symptoms or conditions were proximately caused or aggravated by the duties of her employment. Claimant testified that her symptoms abated while she was off work yet the medical records reflect that Claimant remained symptomatic while she was on extended unpaid leaves of absence. In addition, the Claimant asserts that she initially suffered from neck pain which graduated into headaches, but the medical records reveal the opposite. Claimant also contends that her job duties require repetitive cradling of the telephone with her neck, which both Drs. Lambden and Swarsen agree could

cause or increase neck pain. However, Claimant's neck complaints continued while she was not working and her first report of onset occurred after she started FMLA leave.
In addition, the opinions and reports of Dr. Lambden are more persuasive than those of Dr. Swarsen. Dr. Swarsen's report indicates that first medical records he reviewed began on August 11, 2008, despite Claimant's documented history of complaints to Kaiser physicians prior to August 11. Dr. Swarsen also relied on Claimant's statement that her symptoms improved while she was not working although the records directly contradict Claimant's assertion. Dr. Swarsen's opinion also assumes that Claimant engages in highly repetitive work, which the facts do not support. Dr. Lambden persuasively explained that Claimant suffers from migraine headaches with some myofascial neck pain, neither of which are attributable to her work activities.
Based on the lack of evidence of causation, Claimant has not established that it is more probably true than not that her work duties caused her to develop headaches, neck pain or arm pain or that such pain complaints were a natural incident of her work duties. Claimant's pain complaints cannot be fairly traced to her employment because her job duties did not require repetitive activities that would lead to headaches, neck pain or arm pain. Based on the persuasive opinions of Dr. Lambden, Claimant has not developed an occupational disease nor have her job duties aggravated any pre-existing condition. Accordingly, Claimant's workers' compensation claim is denied and dismissed.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation is hereby DENIED and DISMISSED.
2. Because the claim is denied, the Judge need not address the remaining issues endorsed for hearing.

DATED: October 23, 2009

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-767-641

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that she injured her left foot during the course and scope of her employment with Employer on September 23, 2007 or August 4, 2008.

2. Whether Claimant has demonstrated by a preponderance of the evidence that she is entitled to authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury.

STIPULATIONS

The parties agreed to the following:

1. Claimant earned an Average Weekly Wage (AWW) of $767.08.

2. If Claimant suffered a compensable injury, she is entitled to receive Temporary Total Disability (TTD) benefits for the period September 9, 2008 through November 7, 2008.

FINDINGS OF FACT

1. Claimant worked for Employer as a corrections officer in Sterling, Colorado assigned to the kitchen. On September 23, 2007 a food cart ran over the back of Claimant's left foot. Claimant visited the Emergency Room at Sterling Regional Medical Center and an initial assessment revealed a mild edema on the back of the left calcaneous or heel. Claimant was diagnosed with a left heel contusion.

2. X-rays of Claimant's left heel were essentially negative. However, on the medial aspect of the navicular bone in Claimant's left foot there appeared to be a healing osteophyte or callus formation. The radiologist characterized the formation as subacute or chronic. The radiologist questioned whether there was any correlation between Claimant's heel injury and the navicular bone findings. The emergency room physician also commented on Claimant's old callus formation.

3. Employer directed Claimant to designated medical provider Robert J. Fillion, D.O. On September 25, 2007 Claimant visited Dr. Fillion for an examination. She reported pain "confined to the inferior-posterior left calcaneous." Dr. Fillion remarked that the emergency room x-rays revealed a previous left navicular fracture and a density on the posterior calcaneous.

4. On October 18, 2007 Claimant again visited Dr. Fillion for an evaluation. Claimant reported that she had been performing activities without any symptoms and did not require medication. Dr. Fillion noted that Claimant did not have any "tenderness to palpation at the left ankle mortise, heel, and/or Achilles." He remarked that Claimant had suffered left Achilles tendinitis that had resolved with "absence of any sequelae." Dr. Fillion thus determined that Claimant had reached Maximum Medical Improvement (MMI) with no impairment.

5. Following her release from Dr. Fillion, Claimant resumed her normal kitchen duties until she was transferred to the Recreation Department in June 2008. Her duties involved working in the gym, supervising inmates and delivering equipment. Shortly after her transfer Claimant began to experience recurrent left foot symptoms. Claimant's soreness increased until the second or third week of July when she could no longer tolerate weight on her left foot.

6. On August 4, 2008 Claimant reported her left foot symptoms to her supervisor. She attributed her foot condition to the September 23, 2007 incident when the food cart struck her left heel.

7. On August 4, 2008 Claimant visited the Family Care Clinic for an evaluation. She was examined by Halim S. Abou Faycal, M.D. Claimant reported that she had not had "any problems at all" since the September 23, 2007 cart incident. Dr. Abou Faycal noted that Claimant had "[q]uestionable early left plantar fasciitis versus Achilles tendinitis." After diagnostic studies, Dr. Abou Faycal diagnosed Claimant with a left foot medial navicular fracture. He directed Claimant to orthopedic specialist Darrel T. Fenton, D.O. for an evaluation.

8. On August 8, 2008 Claimant underwent CT scans of both feet and ankles. The radiologist explained:

> Along the medial aspect of the right navicular [right foot], there is a partially fused ossicle, normal variant. Along the medial aspect of the left tarsal navicular [left foot] is a well corticated ossification, which likely represents an accessory navicular bone or less likely, an old unhealed fracture.

9. Dr. Fenton reviewed Claimant's CT scans. He determined that Claimant suffered from a disrupted accessory navicular instead of a true fracture. Dr. Fenton recommended an excision of the accessory navicular and advancement of the posterior tibialis with repair. On September 11, 2008 Dr. Fenton performed the procedure.

10. In a September 2, 2009 letter Dr. Fenton explained that Claimant's left foot condition and need for surgery was caused by the September 23, 2007 food cart incident. He remarked that, because Claimant had no left foot problems prior to the cart incident, her injury was "related to the traumatic episode of the cart running over her foot exacerbated with her persistent continued jobs with pushing, trying to keep carts on the concrete [and] doing her job." Dr. Fenton commented that the September 23, 2007 incident aggravated Claimant's condition, increased her medications and caused her to need left foot surgery.

11. Clamant underwent an independent medical examination with podiatrist Paul A. Stone, M.D. Dr. Stone prepared reports and testified at the hearing in this matter. He reviewed Claimant's emergency room records and diagnostic studies. Dr. Stone concluded that Claimant's left foot condition and need for surgery was not caused by the September 23, 2007 cart incident. He instead explained that Claimant's left accessory navicular bone constituted a congenital defect that never fused. Dr. Stone commented that Claimant suffers from the same condition in her right foot but the accessory navicular bone is fused. He remarked that, although the emergency room records revealed a mild edema in Claimant's posterior left heel, there was no indication of "any pain or complaint in the area of the navicular midfoot or forefoot." Dr. Stone finally stated that Claimant only injured her left heel on September 23, 2007 and did not experience pain in the area where Dr. Fenton performed surgery.

12. Claimant has failed to demonstrate that it is more probably true than not that she suffered a compensable left foot injury during the course and scope of her employment with Employer on September 23, 2007 or August 4, 2008. Her employment activities on September 23, 2007 and August 4, 2008 did not aggravate, accelerate, or

combine with her pre-existing left foot problems to produce a need for left foot surgery. On September 23, 2007 Claimant suffered a left heel contusion while performing her job duties for Employer. The medical records reflect that Claimant suffered a mild edema in her posterior left heel, but there was no evidence of any pain in Claimant's navicular midfoot or forefoot. Initial x-rays revealed abnormal navicular bone findings in Claimant's left foot that existed prior to September 23, 2007. Dr. Stone explained that Claimant subsequently underwent left foot surgery to remove her left accessory navicular bone. He persuasively noted that the bone constituted a congenital defect that had never fused. Dr. Stone thus credibly concluded that Claimant's left foot condition and need for surgery was not caused by the September 23, 2007 cart incident. In contrast, Dr. Fenton commented that the September 23, 2007 incident aggravated Claimant's condition, subsequent job duties exacerbated her symptoms and she ultimately required left foot surgery. However, Dr. Fenton's explanation is inconsistent with the medical records that documented a work injury limited to Claimant's left heel and the x-rays that revealed a pre-existing left accessory navicular bone.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re*

Swanson, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has failed to demonstrate by a preponderance of the evidence that she suffered a compensable left foot injury during the course and scope of her employment with Employer on September 23, 2007 or August 4, 2008. Her employment activities on September 23, 2007 and August 4, 2008 did not aggravate, accelerate, or combine with her pre-existing left foot problems to produce a need for left foot surgery. On September 23, 2007 Claimant suffered a left heel contusion while performing her job duties for Employer. The medical records reflect that Claimant suffered a mild edema in her posterior left heel, but there was no evidence of any pain in Claimant's navicular midfoot or forefoot. Initial x-rays revealed abnormal navicular bone findings in Claimant's left foot that existed prior to September 23, 2007. Dr. Stone explained that Claimant subsequently underwent left foot surgery to remove her left accessory navicular bone. He persuasively noted that the bone constituted a congenital defect that had never fused. Dr. Stone thus credibly concluded that Claimant's left foot condition and need for surgery was not caused by the September 23, 2007 cart incident. In contrast, Dr. Fenton commented that the September 23, 2007 incident aggravated Claimant's condition, subsequent job duties exacerbated her symptoms and she ultimately required left foot surgery. However, Dr. Fenton's explanation is inconsistent with the medical records that documented a work injury limited to Claimant's left heel and the x-rays that revealed a pre-existing left accessory navicular bone.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request for Workers' Compensation benefits is denied and dismissed.

DATED: October 26, 2009.

Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-725-318

ISSUES

At the commencement of hearing the parties stipulated that the Claimant is entitled to maintenance care. The sole issue for hearing was permanent partial disability.

FINDINGS OF FACT

1. The claim is currently under a General Admission of Liability dated June 27, 2007. The primary authorized treating physician placed the Claimant at maximum medical improvement and provided an impairment rating. Respondents requested a Division Independent Medical Examination (DIME), which was performed on January 28, 2009 by Dr. Will Griffis.

2. Dr. Griffis opined that the Claimant sustained a 14% impairment of the whole person for her cervical injury, a 23% impairment of the right upper extremity for the right carpal tunnel syndrome, and a 3% psychological impairment for depression.

3. The Claimant sought initial treatment on May 1, 2007 at CCOM. Her initial complaints were pain in her right elbow and right forearm with periods of numbness in her forearm, elbow, wrist, and hand. Respondents admitted the claim.

4. The claim was the subject of a prior hearing on May 9, 2008 wherein respondents challenged causation for the left-sided carpal tunnel syndrome. In the Findings of Fact issued by ALJ Stuber, he noted that the insurer admitted for the right carpal tunnel syndrome and for the cervical myofascial condition.

5. The Claimant went on to receive treatment at CCOM and was referred by CCOM to Dr. Donald Luebke, a plastic and reconstructive surgeon. The Claimant underwent the right carpal tunnel release and injection of the right lateral epicondyle by Dr. Luebke on or about July 19, 2007. Thereafter the Claimant continued to complain of right hand tenderness and right elbow pain over the lateral epicondyle.

6. The cervical condition was specifically documented and diagnosed by Dr. Bart Goldman in his evaluation of November 30, 2007, along with the right carpal tunnel syndrome. Dr. Goldman recommended treatment for both conditions. The Claimant was subsequently referred to Dr. David Richman who became the authorized treating physician. Dr. David Richman treated the Claimant primarily for her cervical condition and for depression until Dr. Richman brought the Claimant to maximum medical improvement on August 27, 2008. At that time he opined that the Claimant sustained a 16% impair-

ment due to her cervical condition and a 3% for depression secondary to the industrial injury and resulting pain syndrome. The cervical impairment was subsequently amended by Dr. Richman to be a 12% impairment rating as set forth in his report of November 21, 2008.

7. Dr. Richman did not feel that the right upper extremity was causally related to her work environment. However, in his two depositions; one taken May 7, 2008 in preparation for the first hearing on compensability of the left-sided carpal tunnel syndrome, and on July 1, 2009 in contemplation of the current hearing, Dr. Richman acknowledged that he was less certain on the issue of causation for the right upper extremity because the Claimant was right-handed and utilized a mouse in her computer entry activities at work.

8. Dr. Richman, when specifically asked if he thought the DIME Examiner's assessment of causation for the right upper extremity was "clearly wrong," Dr. Richman acknowledged that he could not state that. Further, when asked whether the impairment rating provided for the cervical spine by the DIME Examiner was clearly wrong, Dr. Richman conceded that it was simply two different approaches; one not necessarily being wrong over the other. The two cervical ratings provided by Drs. Griffis and Richman are very close in their estimate of permanent impairment. They are identical in their assessment of the depression. The only significant difference is whether or not the right upper extremity should also be included. Dr. Richman did not feel it should be included and therefore did not perform the analysis or provide the rating. Dr. Griffis did feel it should be included and provided the rating.

9. Dr. Franklin Shih saw the Claimant at the request of Respondents for purposes of an independent medical examination. Dr. Shih provided his report and was the subject of the evidentiary deposition, which was held on August 4, 2009. It is Dr. Shih's assessment that he could find no impairment for any condition that he would rate in this claim. The basis for his opinion is not clear. Dr. Shih's testimony and report are less persuasive than the testimony and/or medical records provided by Drs. Richman and Griffis. Dr. Shih's opinions are also in direct contradiction to the other treating physicians including Drs. Finn, Olson, Luebke, and Goldman. The Claimant underwent two EMG's which documented bilateral carpal tunnel syndrome. The EMG's were not noted by Dr. Shih in his narrative report.

10. Respondents have failed to demonstrate that Dr. Griffis is clearly wrong in any of his assessments as to permanent impairment. It is found that the DIME examiner's report, when considering the weight of the other medical records and the testimony of Dr. David Richman, is more persuasive than the testimony and narrative report from Dr. Franklin Shih. Where Dr. Richman and Dr. Griffis differ, it is found that the Respondents have failed to meet their burden of proof that the DIME examiner's opinions have been overcome by clear and convincing evidence.

CONCLUSIONS OF LAW

Based upon the Findings of Fact, the ALJ makes the following Conclusions of Law:

1. The DIME examiner's finding on permanent medical impairment can only be overcome by clear and convincing evidence. Section 8-42-107(8)(c). Where a party seeks to overcome the DIME examiner's opinion on either maximum medical improvement or medical impairment, the finding of the DIME examiner on these issues "shall be overcome only by clear and convincing evidence." Clear and convincing evidence means evidence which is stronger than a mere preponderance; it is evidence that is highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995).

2. The Court of Appeals stated in *Qwal-Med, Inc. v. ICAO*, 961 P.2d 590 (Colo. App. 1998), "the enhanced burden of proof reflects the underlying assumption that a physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion." *Qwal-Med, Inc.*, *supra*, at 592.

3. The DIME physician's opinions concerning maximum medical improvement and permanent medical impairment are given presumptive effect. These determinations inherently require the DIME examiner to assess, as a matter of diagnosis, whether the various components of the Claimant's medical condition are causally related to the industrial injury. A DIME physician's determinations therefore concern causation and are binding unless overcome by clear and convincing evidence. *Leprino Foods v. Industrial Claim Appeals Office*, 134 P.3d 475 (Colo. App. 2005); *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002).

4. Respondents have failed to meet their burden of proving that the impairment rating provided by Dr. Will Griffis, in his DIME, is clearly wrong. Respondents' request to have the DIME overturned is denied and dismissed.

ORDER

It is therefore ordered that:

1. The Respondent-Insurer shall pay Claimant for permanent partial disability benefits based upon the impairment rating provided by the Division Independent Medical Examiner which is a 23% impairment of the right upper extremity, a 3% psychiatric impairment, and a 14% impairment of the whole person for her cervical injury.

2. The Respondent-Insurer shall pay interest to Claimant at the statutory interest rate of eight percent (8%) on all amounts of compensation not paid when due.

3. The Respondent-Insurer shall pay for reasonable and necessary medical maintenance care after maximum medical improvement.

4. All matters not determined herein are reserved for future determination.

DATE: October 27, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-754-810

ISSUES

The issues for adjudication were:

1. Whether Respondents overcame the Division Independent Medical Examiner's (DIME) opinion with regard to maximum medical improvement (MMI) by clear and convincing evidence.

2. Whether the surgery performed by Dr. Brown was reasonable, necessary, and related to Claimant's March 4, 2008 injury.

3. Whether Respondents overcame the DIME with regard to permanent partial impairment (PPD) by clear and convincing evidence.

4. Whether Claimant is entitled to temporary total disability (TTD) benefits from November 24, 2008 ongoing.

5. Whether Claimant is entitled to an increase in his average weekly wage (AWW).

FINDINGS OF FACT

1. Claimant had a pre-existing low back condition dating back to 1998. At that time, he was diagnosed with a disk herniation at the L4-5 level, and received conservative treatment. His condition improved, but over the years he continued to experience occasional flare-ups including back pain with radiation into his left leg. He did not receive any medical treatment for any of these flare-ups until 2007 when he experienced a significant exacerbation of his condition. He again received conservative treatment and he also missed some time from work. His symptoms almost completely resolved after an epidural steroid injection on April 20, 2007. Claimant then returned to his regular work and recreational activities, although he did continue to miss work due to an unrelated medical condition.

2. On March 4, 2008, Claimant was eating his lunch in the company cafeteria. He slipped on some water and ice on the floor. He began to fall but was able to catch himself, jerking and twisting his back in the process. He experienced an immediate onset of pain in his low back and left leg. Respondents admitted liability for this industrial accident.

3. Claimant received conservative treatment including physical therapy, medications and epidural steroid injections. He had an MRI which showed moderate to advanced degenerative changes of the L4-5 disc space with loss of disc space height, posterior osteophyte formation, hypertrophic arthropathy of the facet joints and bilateral neural foraminal narrowing. He underwent an initial surgical evaluation with Dr. Brown who recommended continued conservative care and monitoring, as well as a follow-up appointment. None of the treatment was effective in resolving symptoms.

4. Dr. Dickson placed claimant at MMI on November 24, 2008 with a 3% impairment rating of the whole person after apportionment. Respondents filed a final admission of liability dated December 5, 2008 terminating temporary disability benefits as of the MMI date. Claimant requested a DIME.

5. In the meantime, Claimant attended his previously scheduled follow-up appointment with Dr. Brown who recommended fusion surgery. Dr. Brown's office submitted a preauthorization request to the Workers' Compensation carrier, which was denied. He underwent the surgery under his private health insurance on March 5, 2009. He underwent the DIME with Dr. Griffis approximately a month later. Dr. Griffis found that the surgery was reasonable, necessary, and related to the industrial injury and as a result stated that Claimant was not at MMI. He did not provide an impairment rating as Claimant was still recovering from the surgery.

6. Respondents failed to prove that it is highly probable Dr. Griffis' opinion regarding MMI is incorrect. The ALJ concludes that totality of the medical evidence, as well as Claimant's testimony, establishes that Dr. Griffis' conclusions and opinion concerning Claimant's not being at MMI has not been overcome by clear and convincing evidence.

7. The ALJ concludes that the fusion surgery performed by Dr. Brown was reasonable, necessary, and related to the industrial injury. The credible medical evidence of record establishes that Claimant's back surgery performed by Dr. Brown on March 5, 2009 was reasonable, necessary, and related to Claimant's industrial injury of March 04, 2008. To the extent that Respondents' experts testified to the contrary, their testimony was not persuasive. Claimant is entitled to medical benefits for the surgery, as well as any out-of-pocket expenses he has incurred.

8. Claimant continues to be disabled and miss work due to the Claimant's industrial injury of March 04, 2008. Because he is not at MMI, there is no legal basis for the termination of his temporary disability benefits. He is entitled to temporary disability benefits retroactive to November 24, 2008.

9. In this case, the parties have stipulated to a base average weekly wage of $747.66. Respondents terminated Claimant's health benefits retroactive to June 12, 2008. There is no evidence in the record that the Respondenrt-Employer continued to pay its contribution to the cost of the benefits after the date of the termination. Claimant was added to his wife's policy as of March 4, 2009. The parties have stipulated that the cost of continuing his benefits are as follows:

06/12/08 - 12/31/09	$101.15
01/01/09 - 03/03/09	87.81
03/04/09 - continuing	25.38

CONCLUSIONS OF LAW

1. Pursuant to § 8-42-107(8)(b)(III), C.R.S. 2009, a DIME physician's finding of MMI is binding on the parties unless overcome by clear and convincing evidence. *Montoya v. Industrial Claim Appeals Office* 203 P.3d 620 (Colo. App. 2008); *Brownson-Rausin v. Industrial Claim Appeals Office* 131 P.3d 1172 (Colo. App. 2005). "Clear and convincing" evidence has been defined as evidence which demonstrates that it is "highly probable" the DIME physician's opinion is incorrect. *Qual-Med, Inc., v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Metro Moving & Storage Co. v. Gussert,* 914 P.2d 411 (Colo. App. 1995). The question whether a party has overcome the DIME by clear and convincing evidence is one of fact for the ALJ's determination. *Metro Moving & Storage Co. v. Gussert, supra.* As found, Respondents failed to prove that it is highly probable Dr. Griffis' opinion regarding MMI is incorrect.

2. Respondents are liable to provide medical treatment that is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101 (1)(a), C.R.S. 2005. The question of whether the Claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002). Claimant also must prove a causal relationship between the industrial injury and the medical treatment for which he seeks benefits. *Snyder v. Indus. Claim Appeals Office*, 942 P.2d 1337 (Colo.App. 1997). As found Claimant's back surgery performed by Dr. Brown on March 5, 2009 was reasonable, necessary, and related to Claimant's industrial injury of March 04, 2008.

3. Because Claimant is not at MMI, the issue of permanent disability is not yet ripe.

4. Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused Claimant to leave work, and Claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). As found, Claimant is entitled to temporary disability benefits retroactive to November 24, 2008.

5. “The term ‘wages’ shall include the amount of the employee's cost of continuing the employer's group health insurance plan and, upon termination of the continuation, the employee's cost of conversion to a similar or lesser insurance plan. . . . 8-40-201(19)(b), C.R.S. The Claimant's cost of continuing the employer's group health insurance plan must be included in the average weekly wage even if Claimant does not actually purchase replacement health insurance. *Industrial Claim Appeals Office v. Ray*, 145 P.3d 661 (Colo. 2006). As found, Claimant’s health benefits were terminated on June 12, 2008 and there is no evidence in the record that the employer continued to pay its contribution for the benefits after that date. Claimant is entitled to an increase in the average weekly wage after June 12, 2008 in the amounts stipulated by the parties.

ORDER

It is therefore ordered that:

1. Respondents are responsible for the payment of medical benefits, in accordance with the established fee schedule, including the March 5, 2009 surgery, as well as any out-of-pocket expenses Claimant has incurred.
2. Respondents shall pay temporary disability benefits to the Claimant in accordance with the rates stipulated by the parties as stated in paragraph 10 of this order. Payment shall be retroactive to November 24, 2008 and continuing until terminated pursuant to 8-42-105(3), C.R.S.
3. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
4. All matters not determined herein are reserved for future determination.

DATE: October 27, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS’ COMPENSATION NO. WC 4-781-304

ISSUES

¬ Did claimant prove by a preponderance of the evidence that his shoulder injury is not a loss enumerated on the schedule of specific injuries such that his loss should be compensated based on impairment of the whole person?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

1. Claimant is a 47-year-old male who worked for employer as a service technician for heating, ventilation, and air conditioning systems. On October 20, 2008, claimant was working on a freezer when a forklift collided with the scaffolding on which he was standing, causing it to collapse and claimant to fall some 15-feet to the ground. Claimant was able to continue work with employer, performing office duties. Claimant returned to fieldwork on October 27th, lifted a ladder, and experienced significant pain and loss of range of motion in his right shoulder.

2. Employer referred claimant to John W. Dunkle, M.D., who evaluated him on October 28, 2008. Dr. Dunkle diagnosed a probable complete tear of the rotator cuff of the right shoulder. Dr. Dunkle ordered a magnetic resonance imaging (MRI) scan of claimant's right shoulder and referred him to Orthopedic Surgeon Cary R. Motz, M.D.

3. Claimant underwent the MRI scan on October 28, 2008, which showed moderate glenohumeral degenerative arthritis, a chondral defect, a subchondral bony cyst, and circumferential complex and probable degenerative tearing throughout the labrum. In addition, the MRI showed intra-articular biceps tendinopathy without a tear or subluxation, and mild narrowing of the acromion outlet without bursitis.

4. Dr. Motz examined claimant on October 30, 2008, and reviewed the right shoulder MRI. Claimant told Dr. Motz that he had prior right shoulder pain over the years due to excessive use. Dr. Motz diagnosed right shoulder impingement with chondromalacia. Dr. Motz administered a right shoulder steroid injection into the subacromial space, and he recommended that claimant undergo physical therapy. Dr. Motz administered another steroid injection on December 4, 2008. Claimant reported to Dr. Motz on January 8, 2009, that the injection provided only a little relief and that he continued to have moderate discomfort. Dr. Motz recommended right shoulder surgery.

5. On January 21, 2009, Dr. Motz performed right shoulder arthroscopic surgery to decompress the subacromial space, with extensive debridement of the glenohumeral joint and with debridement of a partial thickness tear of the supraspinatus tendon. Dr. Motz's pre-operative diagnosis was right shoulder glenohumeral degenerative arthritis; his post-operative diagnosis was right shoulder glenohumeral degenerative arthritis, subacromial impingement, and Grade A-II partial thickness rotator cuff tear.

6. Following his surgery, claimant continued to treat with Dr. Dunkle and Dr. Motz. On January 26, 2009, Dr. Dunkle noted that Dr. Motz had not fixed claimant's rotator cuff tear and that claimant understood this was because of the extent of his pre-existing arthritis and the expected worsening if a repair were attempted. On January 29, 2009, Dr. Motz reported that claimant was doing well one week after surgery and reporting no significant problems. Dr. Motz reported that, in light of significant degenerative arthritis, he elected against surgical repair of the partial tear of claimant's rotator cuff. Dr. Motz prescribed post-operative physical therapy to work on his range of motion.

7. Claimant underwent physical therapy between February 4 and March 20, 2009. During his physical therapy intake, claimant reported difficulty sleeping secondary to pain. Functional and pain issues documented in the therapy notes included problems with weakness, range of motion at the shoulder, pain in the shoulder with lifting, and pain with use of his arm.

8. On February 19, 2009, Dr. Motz reported that claimant continued to do reasonably well, with some discomfort. Dr. Motz felt that the pain claimant was experiencing at that time was due to his arthritis. On February 26, 2009, Dr. Dunkle noted claimant reporting only little improvement since surgery. Dr. Dunkle also noted that Dr. Motz felt the only other option for claimant's symptoms involved total shoulder replacement, but that option would not be considered unless there was significantly more pain and less function. Dr. Dunkle predicted claimant's significant, underlying degenerative joint disease likely would lead to a poor outcome. In his report dated March 26, 2009, Dr. Dunkle noted that claimant reported pain usually at a 3 out of 10. Dr. Dunkle referred clamant for a functional capacity evaluation (FCE).

9. On April 8, 2009, claimant underwent the FCE with Occupational Therapist Julie Chabot, OTR. Based on test results, Therapist Chabot recommended that claimant restrict his work to the light work category. Therapist Chabot further recommended that claimant avoid lifting and twisting outside of his body space and that, when working overhead, he should avoid prolonged overhead reaching.

10. In his report of April 9, 2009, Dr. Motz noted claimant doing well, but that he had some expected discomfort. Dr. Motz felt claimant had reached maximum medical improvement (MMI) from an orthopedic standpoint.

11. Dr. Dunkle placed claimant at MMI on April 10, 2009. Dr. Dunkle rated claimant's permanent medical impairment at 13% of the upper extremity, which he converted to 8% of the whole person. Dr. Dunkle reported:

> [Claimant's] prognosis is for waxing and waning symptoms. There is no anticipated precipitous or gradual deterioration. **Any worsening of [claimant's] condition would be attributed to the natural progression of an underlying degenerative process.**

(Emphasis added). Dr. Dunkle outlined permanent work restrictions of lifting limited to 30 pounds occasionally to chest height, no reaching or lifting above chest height with the right arm. Dr. Dunkle limited claimant's right hand lifting to 6 pounds and advised him to avoid crawling.

12. On April 20, 2009, insurer filed a Final Admission of Liability (FAL), admitting liability for permanent partial disability (PPD) benefits based upon Dr. Dunkle's rating of 13% of the upper extremity. On May 18, 2009, claimant objected to the FAL and requested a hearing, claiming his PPD benefits should be based upon whole person impairment.

13. Respondents referred claimant to Scott Primack, D.O., for an independent medical examination. In his report of August 5, 2009, Dr. Primack noted that claimant's main limitations from the injury involve any lifting with his right arm. Dr. Primack noted that, upon physical examination, claimant had full range of motion of his cervical spine and that all cervical tests were normal. Dr. Primack concluded:

> Based upon the history, clinical examination, the review of the medical record, and the Functional Capacity Evaluation the [claimant] should have an upper extremity rating. It is clear that his area of functional impairment is at the right arm. There is no cervical spine pathology. There is no left shoulder pathology. When the patient describes his limitations, it is clear

> that this is at the level of the right arm. Thus, to within a reasonable degree of medical probability, the [claimant's] injury should be considered a scheduled impairment of the upper extremity.

At the request of respondent's counsel, Dr. Dunkle reviewed Dr. Primack's report to offer an opinion whether claimant's shoulder impairment should be compensated as a scheduled versus whole person impairment rating. Dr. Dunkle agreed with Dr. Primack that claimant's injury should be reported as an upper extremity injury, and not as a whole person injury.

14. Claimant showed it more probably true that the situs of the pathology from his injury involves anatomical structures of the shoulder that are proximal (above or lateral) to the glenohumeral joint and distal to (below) the glenohumeral joint. Crediting Dr. Primack's testimony, the Judge finds: The acromion is the bony structure that forms the roof of the glenohumeral joint. Dr. Motz surgically decompressed the subacromial space below the acromion bone by shaving off the tip of the acromion, which is located above the glenohumeral joint. Dr. Motz shaved the tip of the acromion because it was contributing to loss of space at the glenohumeral joint, or impingement of the shoulder. As part of the decompression procedure, Dr. Motz also surgically released (shortened) the coracoid-acromial ligament, which is a ligamentous structure above the glenohumeral joint. Dr. Motz also debrided (roughened) the supraspinatus tendon, which inserts or attaches at the greater tuberosity of the humerus bone and which is part of the shoulder and arm.

15. Crediting Dr. Primack's testimony, the Judge finds: The function of the shoulder is to move the arm. Functional impairment of the shoulder thus is measured by loss of range of motion of the arm. Claimant experiences problems with pain in the muscles of the trapezius and scapular region of his shoulder girdle proximal to the glenohumeral joint, but that pain is expressed in limited motion or function of the arm. The pain claimant experiences in the trapezius, scapular, and pectoralis muscles likely represents referred pain from his torn rotator cuff, but not an injury to the muscles themselves. Claimant experiences this referred pain even when he is not moving his arm.

16. Claimant's testimony was credible. Claimant understood from Dr. Motz that he elected not to repair the torn rotator cuff because repairing the partially torn tendon would tighten the shoulder too much and cause improper wear. Claimant experiences pain at a level of 3 to 5 / 10 in the muscles of his shoulder girdle, radiating into his neck. Those muscles tighten when he is not using his shoulder. This affects motion in his neck when looking to his left, such that he can only turn his head to a limited point before having to turn his torso as well. Claimant experiences headaches because of muscle pain in his shoulder girdle and neck region. Claimant has problems sleeping because he finds it difficult to find a comfortable position. Medications help claimant to sleep more fully. Claimant is unable to use his right upper extremity to reach overhead because of pain.

17. Claimant showed it more probably true than not that the situs of the functional impairment from his injury involves anatomical structures that affect his functioning above and below the glenohumeral joint (shoulder joint). As found, the situs of pathology from claimant's injury involves the acromion, the coracoid-acromial ligament, and

the supraspinatus tendon, all of which are structures of the shoulder at and above the glenohumeral joint. Impairment of the shoulder joint is measured by loss of motion or loss of use of the arm, even though the situs of the injury involves structures above and at the glenohumeral joint. Because he experienced a permanent loss of range of motion (functional impairment) of his right arm, claimant sustained permanent impairment of the right shoulder. The Judge finds that impairment of the shoulder is not a loss listed on the schedule of disabilities; thus, claimant's shoulder impairment should be compensated based upon impairment of the whole person. In addition to shoulder impairment, claimant also experiences pain in muscles of the shoulder girdle and pectoralis region, all of which are proximal to the glenohumeral joint on the trunk of claimant's body. Claimant's shoulder girdle pain impairs his ability to move his neck as well as his ability to move his right arm. Claimant's shoulder pain also affects his ability to sleep (a function of daily living) and causes him occasional headaches. The Judge infers that claimant's headaches affect his general functioning. Claimant thus showed it more probably true that he sustained permanent functional impairment involving regions of his body that are proximal to the glenohumeral joint and involve functioning that is not measured only by loss of range of motion of his right arm. The situs of this functional impairment is proximal and above the loss of the arm measured at the shoulder.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Claimant argues he has proven by a preponderance of the evidence that his PPD benefits should be based upon impairment of the whole person because the functional impairment he sustained from his shoulder injury represents a loss that is not enumerated on the schedule of specific injuries. The Judge agrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

The term "injury" refers to the part of the body that has sustained the ultimate loss. *Mountain City Meat Co. v. Oqueda,* 919 P.2d 246 (Colo. 1996). In the context of §8-42-107(1), the term "injury" refers to the part or parts of the body that have been functionally impaired or disabled as a result of the injury. *Maree v. Jefferson County Sheriff's Department*, W.C. No. 4-260-536 (ICAO August 6, 1998), citing *Strauch v. PSL*

Swedish Healthcare, 917 P.2d 366 (Colo. App. 1996). Section 8-42-107(1)(a), C.R.S. (2003), limits medical impairment benefits to those provided in subsection (2) where the claimant's injury is one enumerated on the schedule. The schedule of specific injuries includes, in §8-42-107(2)(a), the loss of the arm at the shoulder; however, impairment of the shoulder is not listed in the schedule of disabilities. *Maree v. Jefferson County Sheriff's Department*, *supra*. Although §8-42-107(2)(a) does not describe a shoulder injury, our courts have construed that the dispositive issue is whether the claimant sustained a functional impairment to the portion of the body that is listed on the schedule of disabilities. *See Strauch v. PSL Swedish Healthcare*, *supra*. Thus, the ALJ is constrained to determine the situs of the functional impairment, not the situs of the initial harm, in deciding whether the loss is one listed on the schedule of disabilities. *Id.* Section 8-42-107(1)(b), *supra*, provides that, where claimant sustains an injury not enumerated on the schedule, his permanent medical impairment shall be compensated based upon the whole person.

Pain and discomfort, which limit claimant's use of a portion of his body, may be considered functional impairment. *Beck v. Mile Hi Express, Inc.*, W.C. No. 4-283-483 (ICAO February 11, 1997).

Here, the Judge found that claimant showed it more probably true than not that the situs of the functional impairment from his injury is alike above and below the glenohumeral joint (shoulder joint). Claimant thus proved by a preponderance of the evidence that his PPD benefits should be based upon impairment of the whole person.

The Judge found that the situs of pathology from claimant's injury involves the acromion, the coracoid-acromial ligament, and the supraspinatus tendon, all of which are structures of the shoulder at and above the glenohumeral joint. While the situs of claimant's injury involves structures above and at the glenohumeral joint, functional impairment of the shoulder joint is measured by loss of motion or loss of use of the arm. Because he experienced a permanent loss of range of motion (functional impairment) of his right arm, claimant sustained permanent impairment of the right shoulder. The schedule of specific injuries includes, at §8-42-107(2)(a), the loss of the arm at the shoulder; however, impairment of the shoulder is not a loss listed in the schedule of disabilities. The Judge thus finds that claimant's shoulder impairment should be compensated based upon impairment of the whole person. *See Maree v. Jefferson County Sheriff's Department*, *supra*.

In addition to shoulder impairment, claimant also experiences pain in muscles of the shoulder girdle and pectoralis region, all of which are proximal to the glenohumeral joint, on the trunk of claimant's body. Claimant's shoulder girdle pain impairs his ability to move his neck as well as his ability to move his right arm. Claimant's shoulder pain also affects his ability to sleep (a function of daily living) and causes him occasional headaches. The Judge infers that claimant's headaches affect his general functioning. Claimant thus showed it more probably true that he sustained permanent functional impairment involving headaches, the muscles of his shoulder girdle, and the muscles of his neck. These areas of functional impairment involve regions of claimant's body that

are proximal to the glenohumeral joint and involve functioning that is not measured only by loss of range of motion of his right arm. The situs of this functional impairment is proximal and above the loss of the arm measured at the shoulder.

The Judge concludes that insurer should pay claimant PPD benefits based upon Dr. Dunkle's rating of 8% of the whole person. Insurer may credit against this award any PPD benefits it has paid claimant under the FAL.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. Insurer shall pay claimant PPD benefits based upon Dr. Dunkle's rating of 8% of the whole person.

2. Insurer may credit against this award any PPD benefits it has paid claimant under the FAL.

3. Insurer shall pay claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

4. Issues not expressly decided herein are reserved to the parties for future determination.

DATED: _October 27, 2009__

Michael E. Harr,
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-765-977

ISSUES

The following issues were raised for consideration at hearing: Claimant endorsed medical benefits, specifically, authorization for a left shoulder MRI and an abdominal CT scan, both of which have been denied by Respondents. Respondents endorsed medical benefits, including an Order that Claimant's bilateral shoulder problems, headaches, and continued complaints of neck pain are not work-related and Claimant's work-related injury is for a cervical strain.

FINDINGS OF FACT

Having considered the evidence presented at hearing, the following Findings of Fact are entered.

1. Claimant objects to the issue of the relatedness of the right and left shoulder conditions, continued cervical spine/neck complaints, and headaches being raised at hearing in this matter. Claimant contends that Respondents failed to give notice of the issue in the response to application for hearing or in the case information sheet and, therefore, Claimant argues it was not properly raised in this proceeding and should be stricken.

2. It is found that Respondents properly raised the issue of the relatedness of the right shoulder, left shoulder, continued cervical spine/neck complaints, and headaches in this proceeding. Respondents' response to the application for hearing and case information sheet raise the issue of Respondents' challenge regarding the relatedness of the medical benefits sought by Claimant. Part and parcel of that issue is the question whether Claimant's right shoulder, left shoulder, cervical spine/neck, and headaches are related to the work injury. It is found that this notice is adequate to apprise and prepare Claimant for the need to address this issue at hearing.

3. Claimant testified that she began having upper back and neck pain in 2007 while working for Employer and she began seeing Dr. Snodgrass.

4. Dr. Snodgrass evaluated Claimant in March 2006, for complaints of bilateral shoulder pain prior to the admitted work injury. Dr. Snodgrass also treated Claimant for back pain and left hip bursitis prior to the admitted work injury. By September 21, 2007, Dr. Snodgrass noted that Claimant's bilateral shoulder pain improved.

5. On January 17, 2008, Claimant was seen again by Dr. Snodgrass for pre-existing bilateral shoulder pain, neck pain, and back pain.

6. On March 4, 2008, Dr. Snodgrass assessed muscle spasm in Claimant's back and neck pain. He commented that he examined Claimant's workspace and recommended a 2-3 inch platform on which she may stand to type. Dr. Snodgrass' March 31, 2008, diagnosis included neck pain.

7. Claimant filed a claim for worker's compensation alleging injuries to her neck, back, both arms, and both shoulders with a date of onset of April 1, 2008, from repetitive work at or above shoulder level. Respondents filed a General Admission of Liability for medical benefits only on August 1, 2008.

8. Claimant's testified that her job duties, including reaching overhead for labels and to answer the telephone, caused her to experience neck, back and bilateral shoulder pain. Claimant's job duties also included putting data in computers, labeling medication, greeting customers and taking prescriptions. Claimant generally worked Monday through Friday from 8:00 a.m. to 6:00 p.m. with a 30-60 minute lunch break and additional breaks, as needed.

9. Claimant was first seen by Employer's designated provider, William Reents, M.D., on April 3, 2009. Dr. Reents diagnosed cervical strain and referred Claimant to physical therapy. Dr. Reents also gave Claimant temporary work restrictions to avoid leaning her head to the left more than 20 seconds at a time and to avoid repetitive up and down motion of the head.

10. Dr. Reents reported that Claimant worked as a pharmacy technician for Employer and the previous July or August, she started to notice increasing pain in her neck and right trapezius muscles and upper back. Dr. Reents also noted that David Snodgrass, M.D., recommended ergonomic changes to Claimant's work station and that in the previous month, a platform was built so that when Claimant was working at the computer, she was at a much better level than she had been previously when she had to reach up to the computer.

11. Dr. Reents documented clinical examination findings from April 3, 2008, indicated that Claimant's shoulder range of motion was excellent and that there were no impingement signs in her shoulder. Claimant's exam also revealed that when Claimant uses her biceps or triceps, it hurts up into the neck. It hurts her to move her head to the left much more than the right. It hurts to go up and down with her neck.

12. Although Dr. Reents' April 3, 2008 note states that it hurt Claimant to move her head to the right much more than the left, in his May 2, 2008, note he corrected himself stating that Claimant has pain with movements to the left more than the right and he wrote this incorrectly in his April 3, 2008, note.

13. Dr. Reents testified that the significance of impingement signs are when a patient complains of shoulder pain, one of the main things that a physician is trying to differentiate is whether the pain is coming from the strained muscles in the neck or from a cervical disc that causes a pinched nerve from the right side of the neck going down to the shoulder, or it is primarily a shoulder problem, which is a completely different problem. As Dr. Reents explained:

> And one of the more common shoulder problems is impingement syndrome or rotator cuff tendonitis, and in those situations it hurts to move the shoulder. It hurts especially to abduct the shoulder or internally or externally rotate the shoulder.
>
> And when I say she had no impingement signs, that means that she could abduct her shoulder well, she could internally and externally rotate her shoulder well without significant pain, and flex her shoulder and extend her shoulder without significant pain.

14. On April 3, 2008, Dr. Reents diagnosed "neck pain with pain referred to the right trapezius." He opined that this pain was not caused by work, but it was aggravated by Claimant's work. The doctor opined that Claimant's shoulder motion was excel-

lent and there were no impingement signs. Dr. Reents scheduled Claimant for a cervical spine X-ray and noted that Employer already made modifications to Claimant's workstation and that does seem to be helping.

15. Dr. Reents testified that the trapezius is a muscle in the neck and that Claimant's trapezius pain was coming from the neck. Dr. Reents testified that Claimant's pain was on the right side of her neck going down to the right shoulder. Claimant did not complain at all of left sided neck pain or left shoulder pain.

16. Dr. Reents explained that Claimant had pain in the right side of the neck and trapezius, which is close to the shoulder, but that the pain Claimant had going down to the shoulder was pain caused by the neck strain.

17. Based upon his examination, Dr. Reents ruled out bilateral shoulder impingement syndrome, and would not recommend a MRI for either shoulder because it was not necessary in light of his clinical exam findings and Claimant's ability to abduct and internally and externally rotate her right shoulder without pain.

18. Claimant left Employer in April 2008. By May 2, 2008, Dr. Reents reported that Claimant was working at Wal-Mart as a pharmacy technician and that Claimant felt that the ergonomic positioning of her chair and her computer was better at Wal-Mart than it was at Employer. Claimant did not have to put her head against the phone and could hold the phone in her hand at Wal-Mart and the height of the computer was better at Wal-Mart. At the time of the hearing, Claimant continued to work at Wal-Mart.

19. On May 2, 2008, Dr. Reents again diagnosed cervical strain and noted exam findings that Claimant extending her neck is mildly painful, flexion of the neck was more painful and no radicular pain or weakness in the arms and normal arm reflexes. The trapezius muscle was tender. Dr. Reents reported that Claimant's cervical spine X-ray was normal, so "hopefully this is just a muscular problem that can be helped with PT and good ergonomics at work."

20. On June 11, 2008, Dr. Reents reported that Claimant continues to work for Wal-Mart pharmacy where they have a good ergonomic workplace for her. She is improving steadily. Dr. Reents also opined that Claimant's neck strain was improving and he expected Claimant to be at MMI with no impairment in one month.

21. On July 10, 2008, Dr. Reents documented that Claimant had a "surprisingly slow recovery." Dr. Reents reviewed a physical therapy note indicating that the physical therapist was disappointed in Claimant's attendance and that she averaged about once a week for a total of 11 visits and 3 no shows. The therapist reported: "inconsistent effort and testing. He measured only 24 degrees of extension. I think she has more like 40-50 degrees today. I think her flexion was almost complete. He measured her side bending to be a little reduced. She complains after having looked up recently her pain got a lost worse this last weekend. She had to look up a little more than usual at work. Usually she doesn't have to do that very much."

22. Dr. Reents released Claimant to full duty on July 10, 2008.

23. Dr. Reents referred Claimant to Gregory Reichhardt, M.D., a physiatrist, "to see if they can come up with some other ideas as to how to decrease her pain." He noted that he would follow-up with Claimant in 6 weeks. No persuasive evidence was submitted indicating that Dr. Reents was no longer a treating physician or was de-authorized after he referred Claimant to Dr. Reichhardt.

24. Dr. Reichhardt began treating Claimant in August 2008, and has continued to treat Claimant for the past 13 months and treatment is ongoing.

25. On August 8, 2008, Dr. Reichhardt took a history from Claimant that she had a gradual onset of pain over the neck and bilateral upper extremities over the course of the last year. Claimant related her symptoms to ergonomic factors at her workplace for Employer, specifically, reaching for labels off of a printer and off of a phone that were positioned in an overhead position. This required Claimant to reach away from the body at a level just overhead. At times, Claimant would have to stand on her tiptoe in order to reach. Claimant also had to reach for the phone about 10 times per day and that Claimant is 4 feet 11 inches and the workspace was designed for someone taller. Dr. Reichhardt also documented that Employer made ergonomic modifications one month before Claimant left Employer and went to work for Wal-Mart where she does not have any ergonomic problems.

26. Dr. Reichhardt reported that Claimant had a cervical strain and that his examination was suggestive of bilateral shoulder impingement. A cervical MRI was recommended to rule out a C6-7 disc herniation. Dr. Reichhardt also diagnosed headaches and prescribed Topamax. Dr. Reichhardt noted that Claimant was able to work full duty and did not have work restrictions.

27. By September 5, 2008, Dr. Reichhardt assessed neck and shoulder pain with a possible cervical pain generator and possible left shoulder impingement. He stated that he could not rule out a full thickness rotator cuff tear of the left side given the patient's exam. Dr. Reichhardt also noted that Claimant reported difficulty tolerating her pain throughout the course of the day and "was wondering about being taken off of work." No work restrictions were given and Claimant continued with a full duty work release.

28. On October 3, 2008, Dr. Reichhardt reported that Claimant presents for follow-up today, noting that she is doing somewhat worse. She continues to have neck pain with pain over both upper trapezius areas. She has pain over the left shoulder. She has interscapular pain. She has numbness in both hands, in digits three and four, with symptoms most prominent at night when she is trying to sleep. Her hands wake her up at night. She continues to have headaches.

29. Dr. Reichhardt noted that Claimant has "decreased right shoulder range of motion" and "she has a positive left shoulder impingement signs." By October 16, 2008, Dr. Reichhardt assessed left shoulder pain, neck pain, right shoulder pain, headaches and electro diagnostic evaluation demonstrating bilateral carpel tunnel syndrome. He went on to state that: "it would appear that her work activity could potentially cause or aggravate shoulder problems."

30. Dr. Reichhardt testified that Claimant's work-related diagnoses include left shoulder pain, myofascial pain, impingement, possible left bicep tendonitis and possible left rotator cuff tear. Dr. Reichhardt also diagnosed right shoulder impingement and myofascial involvement. Dr. Reichhardt also believes that Claimant suffers from headaches that are myofascial in nature. According to Dr. Reichhardt, the myofascial pain in Claimant's shoulders extends up towards Claimant's neck region, which triggers tension type headaches.

31. Dr. Reichhardt also admitted that he discussed this case once with Dr. Reents by telephone and Dr. Reents advised that Claimant did not mention any left shoulder complaints. Dr. Reichhardt admitted that Claimant's diagnosis of carpal tunnel syndrome is not work-related.

32. According to Reichhardt, there is an early physical therapy note, which "discussed symptoms in the 'shoulders.' This plural reference suggests that [Claimant] had some symptoms in the left side." Dr. Reichhardt, however, went on to state that: "I have opined that it is probable that the left shoulder complaints are work-related; however, this is not entirely clear."

33. Dr. Reents testified that he was not aware that Dr. Reichhardt diagnosed bilateral shoulder impingement. According to Dr. Reents, Claimant did not have bilateral shoulder impingement during the time he treated Claimant. According to Dr. Reents, the bilateral shoulder impingement diagnosis and/or rotator cuff tear diagnosis, if made, must be related to something other than the work injury.

34. Dr. Reents credibly explained that if Claimant had a rotator cuff tear of either shoulder from an April 1, 2008, date of injury, "she would certainly have some pain" during the 4 months that he treated her, but Clamant did not complain of left shoulder pain at all and Claimant's right shoulder pain complaints were coming from the trapezius and were related to a diagnosis of cervical strain.

35. Dr. Reichhardt offered no credible explanation why he would relate a bilateral shoulder impingement or left rotator cuff tear diagnosis to the work injury with an April 1, 2008, date of onset when Dr. Reents did not diagnose either condition during the 3 months he treated Claimant from April 3, 2008 to July 10, 2008.

36. The ALJ finds Dr. Reents' testimony credible.

37. Deborah Saint-Phard, M.D., conducted an IME and issued a report on December 12, 2008.

38. Dr. Saint-Phard credibly testified that Claimant's bilateral shoulder complaints, including bilateral shoulder impingement and left rotator cuff tear, are not work-related. The need for a shoulder MRI is not related to the work injury because Claimant's shoulder problems, whether they include impingement syndrome, rotator cuff tear, or shoulder symptoms, are not work-related.

39. Dr. Saint-Phard disagreed with Dr. Reichhardt's opinion that the myofascial pain and/or impingement syndrome in Claimant's shoulders extended up towards Claimant's neck region, which triggered tension type headaches. Dr. Saint-Phard testified that she agreed with Dr. Reents that Claimant's cervical strain caused trapezius pain and shoulder symptoms, not the converse.

40. Dr. Saint-Phard persuasively explained that Dr. Reents did specific tests to rule out shoulder impingement and to rule out shoulder problems as the pain generator. It is medically probable that if Claimant has a right shoulder impingement, then it's not related to the work injury because it was ruled out by Dr. Reents.

41. Dr. Saint-Phard also persuasively explained that reliance on one physical therapy visit, which documented that Claimant "discussed symptoms in the shoulders" did not imply that Claimant was complaining of left shoulder pain from a left shoulder impingement or left shoulder rotator cuff tear. Dr. Saint-Phard agreed with Dr. Reents that if Claimant had a left shoulder impingement or left rotator cuff tear, Claimant would have presented with greater left shoulder complaints than a reference in one physical therapy note.

42. Dr. Reents also testified that it has been more than 15 months since Claimant left Employer. It was not medically probable that Claimant's current problems, including bilateral shoulder impingement, left rotator cuff tear, or increased shoulder or neck symptoms would be related to job duties that Claimant has not performed in the past 15 months. Claimant's symptoms and medical conditions, according to Dr. Reents, could possibly be aggravated by Claimant's job duties at Wal-Mart or something else, but could not be related back to Claimant's job duties for Employer. Dr. Saint-Phard agreed with these medical opinions by Dr. Reents. The ALJ finds testimony from Dr. Saint-Phard credible.

43. Claimant's testimony that her neck pain and pain in the shoulders was the same as of the date of the hearing that it was when she left the Employer was deemed not credible because this testimony is contrary to the medical records and the fact that Claimant testified that her work at Wal-Mart was ergonomically correct.

44. Dr. Reichhardt admitted that he was troubled by Claimant's continued complaints of neck and shoulder pain when Claimant had been away from the job duties

that caused or aggravated her medical conditions for 15 months and that he does not "have a good explanation for that."

45. Dr. Reents testified that, if the ALJ agreed with his diagnosis for cervical strain, then it was his opinion that Claimant reached MMI on July 10, 2008, without impairment.

46. Dr. Saint-Phard agreed with Dr. Reents that Claimant's work-related diagnosis is cervical strain and that Claimant reached MMI on July 10, 2008, without impairment.

47. On December 5, 2008, Dr. Reichhardt diagnosis included hematuria, non-work-related, and chest pain, non-work-related. Claimant was advised to follow-up with her primary care physician for these problems.

48. On March 16, 2009, Dr. Reichhardt changed his mind stating that he "would support obtaining a Urology consultation under the setting of a worker's compensation claim" because this consult is necessary to rule out complications from Topamax. Claimant underwent an abdominal CT scan for this.

49. On January 30, 2009, Claimant contacted Dr. Reichhardt noting that she had increased pain in her neck this week, "enough that she had to stop what she was doing." By March 6, 2009, Dr. Reichhardt documented that Claimant changed her hours at Wal-Mart from 10 hours to 9 hours because she felt exhausted by the end of the day.

50. Dr. Reichhardt recommended a left shoulder MRI. Respondents denied liability for the left shoulder MRI. Respondents also denied liability for the abdominal CT scan.

51. It is found that Claimant's work-related diagnosis is cervical strain and that Claimant's bilateral shoulder condition and headaches are not work-related. This determination is supported by the opinions of Drs. Reents, Saint-Phard and Ogsbury.

52. The ALJ finds and concludes that Dr. Reents and Dr. Saint-Phard's opinions are more credible and persuasive than the opinions of Dr. Reichhardt with regard to the issue whether Claimant's bilateral shoulders, current cervical spine/neck complaints, and headaches are related to the work injury. Dr. Reents' testimony and medical records establish that Claimant had no complaints of bilateral shoulder pain and had full range of motion in the bilateral shoulders closer to the date of the work injury. Dr. Reents and Dr. Saint Phard's testimony that it is not medically probable that Claimant's right shoulder, cervical spine, and headaches are related to the work injury, in light of Dr. Reents' physical examinations performed closer to the date of injury, is most credible.

53. The ALJ accepts the testimony of Dr. Reents and Dr. Saint-Phard that Claimant's bilateral shoulder condition, including impingement and/or rotator cuff tear,

headaches, and continued complaints of shoulder and cervical pain are not work-related. Claimant's work injury caused a cervical strain.

54. A left shoulder MRI or an abdominal CT scan to rule out kidney stones from Topamax, which Claimant was taking for non-work-related headaches, is not related to the injury in this claim.

CONCLUSIONS OF LAW

Having entered the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. The purpose of the Workers' Compensation Act of Colorado (Act), Sections 8-40-101, C.R.S., *et seq.*, is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. In general, the claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of the respondents. Section 8-43-201, C.R.S.

2. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved. The ALJ need not address every piece of evidence or every inference that might lead to conflicting conclusions. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P. 3d 385 (Colo. App. 2000).

3. Claimant argues that Respondents failed to provide notice that Respondents intended to raise the issue of the relatedness of Claimant's bilateral shoulder condition, cervical spine and neck complaints, and headaches. It is found that the notice provided to Claimant that the relatedness of Claimant's bilateral shoulder problems, current cervical spine/neck complaints and headaches were at issue is adequate to apprise and prepared Claimant for the need to address this issue at hearing. *See Snyder v. ICAO*, 942 P.2d 1337 (Colo. App. 1997*); Jump v. Earthgrains/Sara Lee Bakery Group*, W. C. No. 4-553-695 (December 02, 2005); *Donley v Swinerton & Walberg Company*, W. C. No. 4-447-698 (September 16, 2005); *Hennessy v. Clayton Group Services*, W. C. No. 4-559-467 (December 07, 2004); *Miller v. Saint Thomas Moore Hospital*, W. C. No. 4-218-075 (September 01, 2000). The notice to Claimant appeared in Respondents' response to application for hearing and case information sheet to the extent that Respondents indicated that the issue of the related of medical treatment was raised for consideration at hearing.

4. Claimant bears the burden of proof of showing that medical benefits are causally related to a work-related incident. *See Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997); *Ashburn v. La Plata School District 9R,* W.C. No. 3-062-779 (ICAO May 4, 2007). Once causation is established, Claimant is only entitled

to medical benefits reasonably needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee from the effects of the injury. Section 8-42-101(1)(a), C.R.S.

5. It is the Claimant's burden to prove that the disputed treatment is reasonably necessary to cure or relieve the effects of the industrial injury. *See Ciesiolka v. Allright Colorado, Inc.,* W.C. No. 4-117-758 (ICAO April 7, 2003). While an ALJ may find that a particular condition is related to the industrial injury, they may also find that a specific treatment is not necessary, nor reasonable. *See Terry v. First American Insurance Co*., W.C. No. 4-314-361 (ICAO June 16, 1999).

6. Claimant failed to meet her burden of proving that she suffers from a work-related bilateral shoulder condition, including impingement and rotator cuff tear. Claimant contends that her headaches come from myofascial shoulder pain. Because the shoulder conditions are not work-related, the headaches caused by the shoulder conditions are also not related.

7. The ALJ credits the opinions of Dr. Reents and Dr. Saint-Phard that Claimant's bilateral shoulder condition is not related to the admitted work injury. The ALJ is persuaded by the testimony of Drs. Reents and Saint-Phard. Respondents established that Dr. Reents ruled out right shoulder impingement after his clinical examination and testing of Claimant. Dr. Reichhardt's deposition testimony and medical records do not support the conclusion that Claimant's right shoulder problem, including impingement, relates to the April 1, 2008, date of injury. This is particularly true because after April 1, 2008, and before Claimant started seeing Dr. Reichhardt, right shoulder impingement was ruled out by Dr. Reents.

8. Credible and persuasive evidence established that Dr. Reents did not test for left shoulder impingement because Claimant did not complain of left shoulder pain. Even if the ALJ accepts the reference to Claimant's "shoulder complaints" in an early physical therapy note as indicating that Claimant complained of left shoulder pain, the ALJ is persuaded by the credible opinions of Drs. Reents and Saint-Phard that such minimal complaint is inconsistent with a diagnosis of left shoulder impingement syndrome or left shoulder rotator cuff tear.

9. The ALJ is also persuaded by the opinions of Drs. Reents and Saint Phard that it is not medically probable that Claimant's current problems, including bilateral shoulder impingement, left rotator cuff tear, or increased shoulder or neck symptoms, would be related to job duties that Claimant has not performed the past 15 months. Claimant's symptoms and medical conditions, according to Drs. Reents and Saint Phard, could possibly be aggravated by Claimant's job duties at Wal-Mart or something else, but Claimant failed to establish that they are related to Claimant's job duties for Employer.

10. The ALJ credits the testimony of Drs. Reents and Saint-Phard that Claimant's work injury resulted in a cervical strain for which Claimant reached MMI on July 10, 2008, without impairment. Claimant's bilateral shoulder condition, including impinge-

ment and/or rotator cuff tear, continued complaints of cervical and shoulder problems, and headaches are not related to the work injury in this claim. Consequently, Respondents are not liable for a left shoulder MRI or continued medical treatment for Claimant's shoulder conditions, neck condition or headaches. Respondents are also not liable for an abdominal CT scan which Claimant had to rule out kidney stones or other problem that may have been caused by Claimant's use of Topamax which Claimant took for non-work-related headaches.

ORDER

It is therefore ordered that:

1. Claimant's claim for authorization of a left shoulder MRI and abdominal CT scan are denied and dismissed.

2. Claimant's bilateral shoulder condition, including impingement and/or rotator cuff tear, headaches, and continued cervical complaints are not related to the admitted work injury and Respondents are, therefore, not liable for continued medical treatment for these conditions as Claimant's work-related injury is cervical strain for which Dr. Reents and Dr. Saint Phard opined that Claimant reached MMI on July 10, 2008, without impairment.

DATED: October 28, 2009

Adnistrative Law Judge
Margot W. Jones

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-641-371

ISSUES

1. Whether Claimant has proven by a preponderance of the evidence that his 44% lower extremity impairment rating should be converted to a 26% whole person impairment rating.

2. Whether Respondents have demonstrated by a preponderance of the evidence that the Division Independent Medical Examination (DIME) physician erroneously determined that Claimant had reached Maximum Medical Improvement (MMI) and assigned him a 44% upper extremity impairment rating.

3. Whether Claimant has established by a preponderance of the evidence that the trial of a peripheral nerve stimulator constitutes reasonable and necessary medical treatment designed to cure and relieve the effects of his industrial injury.

4. Whether Respondents have established by a preponderance of the evidence that they are entitled to recover an overpayment from Claimant in the amount of $20,525.98.

5. Whether Claimant is entitled to a disfigurement award pursuant to §8-42-108, C.R.S.

STIPULATIONS

The parties agreed to the following:

1. Claimant has been receiving Social Security Disability Insurance (SSDI) benefits since August 1, 2006.

2. Claimant received SSDI benefits in the amount of $1,251.50 per month.

3. Insurer has not taken an offset for Claimant's SSDI benefits.

FINDINGS OF FACT

1. On February 1, 2005 Claimant was injured during the course and scope of his employment with Employer. He was working in an attic space filled with roof trusses. While attempting to exit the attic space Claimant's ladder slipped out from beneath him. Claimant then fell between the trusses in a space that was approximately fourteen and one-half inches wide. His left arm stretched over his head and he injured his left shoulder area.

2. On June 30, 2005 Claimant underwent a left shoulder arthroscopy with rotator cuff repair and biceps tenodesis. On December 15, 2005 Claimant underwent a second rotator cuff repair surgery. On February 15, 2006 Claimant underwent a third shoulder procedure including the implantation of a graft jacket.

3. Claimant continued to experience left shoulder pain and stiffness. On December 15, 2006 Gareth Shemesh, M.D. performed nerve conduction studies (EMG) on Claimant. The studies revealed "left carpal tunnel syndrome of moderate severity, left distal ulnar sensory neuropathy of unknown etiology, as well as mild denervation of the left biceps brachii." The EMG's were negative for "evidence of peripheral neuropathy, myopathy, brachial plexopathy, or cervical radiculopathy."

4. On February 6, 2007 Armodios Hatzadakis, M.D. determined that surgery was unlikely to improve Claimant's condition and it was reasonable to place him at MMI. On February 19, 2007 Paul Abbott, M.D. placed Claimant at MMI and assigned him a 16% extremity impairment rating based on range of motion deficits in his left shoulder.

5. On March 22, 2007 Carlton Clinkscales, M.D. recommended left wrist surgery for Claimant. The recommended procedures included ulnar nerve transportation, carpal tunnel release and decompression of Guyon's canal. Dr. Clinkscales explained

that a consultation with a brachial plexus specialist was unnecessary because of Claimant's normal EMG.

6. After Claimant declined surgery for his carpal tunnel syndrome and cubital tunnel syndrome Dr. Clinkscales placed Claimant at MMI on August 23, 2007. On September 20, 2007 Sean Griggs, M.D. concurred that Claimant had reached MMI and assigned a 40% upper extremity rating for his left shoulder injury. The impairment rating was comprised of the following: 26% for range of motion loss, 15% for strength loss, and 5% for carpal tunnel syndrome and cubital tunnel syndrome. The rating converted to a 24% whole person impairment. On September 27, 2007 Dr. Abbott concurred that Claimant had reached MMI.

7. On October 11, 2007 Insurer filed a Final Admission of Liability (FAL). The FAL acknowledged liability for Temporary Total Disability (TTD) benefits for the period February 16, 2005 through September 19, 2007, Permanent Partial Disability (PPD) benefits for the period September 20, 2007 through April 23, 2009 and medical maintenance benefits.

8. On October 23, 2008 Respondents filed a Petition to Reopen based on overpayment, error, or mistake. Respondents sought to recover an overpayment based on the SSDI benefits that Claimant had received since August 1, 2006.

9. On June 16, 2008 Claimant underwent a Functional Capacity Evaluation (FCE) with physical therapist Gail Gerig. Ms. Gerig concluded that "objective testing strongly suggests injury to the left brachial plexus affecting both the posterior cord and the inferior trunk." She noted that a brachial plexus evaluation would be appropriate despite a normal EMG study.

10. On July 18, 2008 Claimant underwent a DIME with Edward Fitzgerald, M.D. Dr. Fitzgerald determined that Claimant had not reached MMI because he required the following: (1) a shoulder arthrodesis assessment, (2) a mental health evaluation, and (3) nerve pain medication. Dr. Fitzgerald assigned a prospective 44% left upper extremity impairment rating for Claimant's left shoulder injury. The rating consisted of 23% for range of motion loss and 27% for a brachial plexus nerve injury. He remarked that he "did not find much tenderness" when he palpated Claimant's brachial plexus and commented that Claimant's EMG results were "not in a pattern that would be consistent with brachial plexopathy." However, Dr. Fitzgerald assigned Claimant an impairment rating for a brachial plexus nerve injury based on Ms. Gerig's observations. He did not include carpal tunnel syndrome or cubital tunnel syndrome as part of Claimant's industrial injuries.

11. On November 3, 2008 Dr. Abbott drafted a response to several questions regarding Claimant's status. He stated that a psychiatric consultation and a prescription for nerve pain medication would both constitute medical maintenance treatment. Dr. Abbott remarked that Claimant had reached MMI "pending [a] shoulder arthrodesis evaluation."

12. On November 17, 2008 Claimant underwent a psychiatric independent medical examination with Robert Kleinman, M.D. Claimant told Dr. Kleinman that he was not interested in medication adjustments or psychological treatment. Dr. Kleinman thus concluded that Claimant had reached MMI from a mental health perspective and assigned him a 2% mental health impairment rating.

13. On February 24, 2009 Claimant underwent a shoulder arthrodesis assessment with Dr. Hatzadakis. Dr. Hatzadakis determined that Claimant had reached MMI for his industrial injury. He noted that a shoulder arthrodesis would be "unpredictable in terms of giving [Claimant] pain relief" and thus did not recommend a left shoulder arthrodesis. Dr. Hatzadakis explained that Claimant would "always have significant pain in the shoulder no matter [what] procedure is done" but recommended an evaluation by surgical pain specialist Giancarlo Barolat, M.D.

14. In September 2008 and February-March 2009 Respondents conducted video surveillance of Claimant. Claimant held a shopping basket containing a few items of undetermined weight in his left hand. He also raised his left hand up to forehead level while holding on to a rear lift gate window on a vehicle.

15. On May 20, 2009 Dr. Barolat drafted a letter regarding Claimant's condition. He remarked that Claimant suffered from chronic, severe pain syndrome following multiple shoulder surgeries. Dr. Barolat commented that further surgical procedures to Claimant's shoulder probably would not improve his symptoms and that he suffered "permanent neuropathic pain." He recommended the trial of a left shoulder peripheral nerve stimulator. Dr. Barolat noted that, if the trial was successful, Claimant would be a candidate for permanent implantation at a later date.

16. On May 27, 2009 Floyd Ring, M.D. issued a report after conducting a records review of Claimant's condition. He also testified at the hearing in this matter. Dr. Ring remarked that an EMG is the "gold standard" and best test to determine whether a brachial plexus injury exists. He noted that Claimant's EMG results and activities in the surveillance video were inconsistent with a brachial plexus injury. Dr. Ring recommended against a peripheral nerve stimulator trial because there was no evidence that Claimant sustained a brachial plexus injury and his symptoms were most likely caused by mechanical shoulder pain. He also explained that peripheral nerve stimulators are not approved by the Food and Drug Administration (FDA) and are not an accepted form of treatment for Claimant's mechanical shoulder pain, carpal tunnel syndrome and cubital tunnel syndrome. Dr. Ring stated that nerve pain medication is not an appropriate form of treatment for Claimant's injury, any further changes in Claimant's medication regimen would constitute medical maintenance care and none of the physicians who treated Claimant after August 23, 2007 had prescribed nerve pain medication. He explained that the three surgeries Claimant underwent only affected the anatomy of his left shoulder and the situs of his permanent impairment was limited to his left upper extremity. Dr. Ring concluded that Claimant reached MMI on August 23, 2007.

17. On June 10, 2009 Jeff Raschbacher, M.D. reviewed Claimant's medical records and determined that a nerve stimulator trial was not warranted. He recommended the wrist surgery previously proposed by Dr. Clinkscales.

18. On July 1, 2009 Al Hattem, M.D. reviewed Claimant's medical records and recommended against neurostimulation. He noted that the Guidelines did not support that form of treatment.

19. On July 31, 2009 Claimant visited treating physician Wayne L. Callan, M.D. Dr. Callan recommended the trial of a peripheral nerve stimulator. He reiterated his recommendation on August 4, 2009. Dr. Callan acknowledged that he was not an orthopedist or neurologist and did not decide whether Claimant had reached MMI.

20. Insurer's Claims Representative Amanda Cooper testified at the hearing in this matter. Ms. Cooper explained that Insurer has already paid Claimant for all of the indemnity benefits referenced in its October 11, 2007 FAL. However, Insurer has not yet taken an SSDI offset against any of the indemnity benefits paid to Claimant for the period August 1, 2006 through April 23, 2009. Ms. Cooper noted that Insurer made an error or mistake when it failed to claim the offset in the FAL. The overpayment totaled $20,525.98 based on a 40% upper extremity impairment rating.

21. Claimant testified at the hearing in this matter. Claimant stated that he experiences severe pain in his left shoulder area and into his left arm. His fingers tingle and his arm is weak. Claimant remarked that his symptoms severely and negatively impact his physical and mental well-being.

22. Claimant underwent a disfigurement evaluation at the hearing in this matter. Claimant has two three-inch scars on the back of his left shoulder as a result of his multiple surgeries. He also has one round scar slightly smaller than a dime in the same area. Claimant's whole left clavicle and shoulder area from neck to shoulder is unnaturally elevated from the effects of the February 1, 2005 industrial injury.

23. Claimant has failed to prove that it is more probably true than not that he suffered a functional impairment beyond the arm at the shoulder. Dr. Ring credibly explained that the three surgeries Claimant underwent only affected the anatomy of his left shoulder and opined that the situs of his permanent impairment is limited to his left upper extremity. Although Claimant testified that he experiences pain in his left arm and tingling in his fingers, he also suffers from carpal tunnel syndrome and cubital tunnel syndrome. Because Claimant declined surgery for his carpal tunnel syndrome and cubital tunnel syndrome it is speculative to attribute his arm pain and tingling to his shoulder injury. The record thus does not contain persuasive evidence that the situs of Claimant's functional impairment extended beyond the arm at the shoulder.

24. Respondents have established that it is more probably true than not that Dr. Fitzgerald erroneously determined that Claimant had reached MMI. DIME physician Dr. Fitzgerald concluded that Claimant had not reached MMI because he required the following: (1) a shoulder arthrodesis assessment, (2) a mental health evaluation, and (3)

nerve pain medication. However, the record reveals that the preceding treatments constitute medical maintenance treatment or have already been completed. Initially, Dr. Hatzadakis performed a shoulder arthrodesis assessment on Claimant, did not recommend the procedure and determined that Claimant had reached MMI. Second, Claimant underwent a psychiatric independent medical examination with Dr. Kleinman. Claimant told Dr. Kleinman that he was not interested in medication adjustments or psychological treatment. Dr. Kleinman thus concluded that Claimant had reached MMI from a mental health perspective. Finally, Dr. Ring persuasively explained that nerve pain medication is not an appropriate form of treatment for Claimant's injury, any further changes in Claimant's medication regimen would constitute medical maintenance care and none of the physicians who treated Claimant after August 23, 2007 had prescribed nerve pain medication. Notably, Dr. Abbott also commented that prescriptions for nerve pain medication would constitute medical maintenance treatment.

25. Respondents have also demonstrated that it is more probably true than not that Dr. Fitzgerald erroneously assigned Claimant a 44% upper extremity impairment rating. The impairment rating consisted of 23% for range of motion loss and 27% for a brachial plexus nerve injury. Dr. Fitzgerald commented that Claimant's EMG results were "not in a pattern that would be consistent with brachial plexopathy." Nevertheless, Dr. Fitzgerald assigned Claimant an impairment rating for a brachial plexus nerve injury based on Ms. Gerig's observations. However, Dr. Ring persuasively concluded that Claimant did not suffer a brachial plexus injury. He explained that an EMG is the "gold standard" and best test to determine whether a brachial plexus injury exists. Claimant's EMG results and activities in the surveillance video are inconsistent with a brachial plexus injury. Furthermore, Dr. Clinkscales remarked that a consultation with a brachial plexus specialist was unnecessary because of Claimant's normal EMG. Claimant is thus entitled to a 23% left upper extremity impairment for range of motion loss.

26. Claimant has failed to demonstrate that it is more probably true than not that a peripheral nerve stimulator trial constitutes reasonable and necessary medical treatment designed to cure and relieve the effects of his industrial injury. Initially, Dr. Fitzgerald did not recommend a peripheral nerve stimulator assessment. Dr. Ring recommended against a peripheral nerve stimulator trial because there was no evidence that Claimant sustained a brachial plexus injury and his symptoms were most likely caused by mechanical shoulder pain. He explained that peripheral nerve stimulators are not approved by the FDA and are not an accepted form of treatment for Claimant's mechanical shoulder pain, carpal tunnel syndrome and cubital tunnel syndrome. Finally, doctors Raschbacher and Hattem reviewed Claimant's medical records and determined that a nerve stimulator trial was not warranted. In contrast, Dr. Barolat did not adequately address how Claimant's nerve symptoms were caused by a brachial plexus injury despite a normal EMG.

27. Respondents have established that it is more probably true than not that they are entitled to recover an overpayment from Claimant. Ms. Cooper credibly explained that Insurer has already paid Claimant for all of the indemnity benefits referenced in its October 11, 2007 FAL. Insurer has not yet taken an SSDI offset against any

of the indemnity benefits paid to Claimant for the period August 1, 2006 through April 23, 2009. Ms. Cooper noted that Insurer made an error or mistake when it failed to claim the offset in the FAL. The overpayment totaled $20,525.98 based on a 40% extremity impairment rating. Claimant's SSDI offset rate was $144.40 per week. Respondents may recover thus recover an overpayment in an amount based on this Order at the rate of $144.40 each week.

28. Claimant has two three-inch scars on the back of his left shoulder as a result of his multiple surgeries. He also has one round scar slightly smaller than a dime in the same area. Claimant's whole left clavicle and shoulder area from neck to shoulder is unnaturally elevated from the effects of the February 1, 2005 industrial injury. Claimant is thus entitled to a disfigurement award in the amount of $2,000.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Whole Person Conversion

4. Section 8-42-107(1)(a), C.R.S. limits medical impairment benefits to those provided in §8-42-107(2), C.R.S. when a claimant's injury is one enumerated in the schedule of impairments. The schedule includes the loss of the arm at the shoulder. *See* §8-42-107(2)(a), C.R.S. When an injury results in a permanent medical impairment

not set forth on a schedule of impairments, an employee is entitled to medical impairment benefits paid as a whole person. *See* §8-42-107(8)(c), C.R.S.

5. In resolving whether a claimant has sustained a scheduled impairment, the Judge must determine the situs of a claimant's "functional impairment." *Velasquez v. UPS,* W.C. No. 4-573-459 (ICAP, Apr. 13, 2006). The situs of the functional impairment is not necessarily the site of the injury. *Id.* Pain and discomfort that limit a claimant's ability to use a portion of the body is considered functional impairment for purposes of determining whether an injury is off the schedule of impairments. *Eidy v. Pioneer Freightways*, W.C. No. 4-291-940 (ICAP, Aug. 4, 1998).

6. As found, Claimant has failed to prove by a preponderance of the evidence that he suffered a functional impairment beyond the arm at the shoulder. Dr. Ring credibly explained that the three surgeries Claimant underwent only affected the anatomy of his left shoulder and opined that the situs of his permanent impairment is limited to his left upper extremity. Although Claimant testified that he experiences pain in his left arm and tingling in his fingers, he also suffers from carpal tunnel syndrome and cubital tunnel syndrome. Because Claimant declined surgery for his carpal tunnel syndrome and cubital tunnel syndrome it is speculative to attribute his arm pain and tingling to his shoulder injury. The record thus does not contain persuasive evidence that the situs of Claimant's functional impairment extended beyond the arm at the shoulder.

The DIME Opinion

7. A DIME physician's findings of MMI, causation, and impairment are binding on the parties unless overcome by "clear and convincing evidence." §8-42-107(8)(b)(III), C.R.S.; *Peregoy v. Industrial Claim Appeals Office*, 87 P.3d 261, 263 (Colo. App. 2004). The mere difference of medical opinion does not constitute clear and convincing evidence to overcome the opinion of the DIME physician. *Javalera v. Monte Vista Head Start, Inc*., W.C. Nos. 4-532-166 & 4-523-097 (ICAP, July 19, 2004); *see Shultz v. Anheuser Busch, Inc*., W.C. No. 4-380-560 (ICAP, Nov. 17, 2000). However, the increased burden of proof required by DIME procedures is only applicable to non-scheduled impairments and is inapplicable to scheduled injuries. *In Re Maestas,* W.C. No. 4-662-369 (ICAP, June 5, 2007); *see* §8-42-107(8), C.R.S., *Delaney,* 30 P.3d at 693. Because Claimant suffered a scheduled impairment, Dr. Fitzgerald's DIME opinion is not entitled to increased deference.

8. As found, Respondents have established by a preponderance of the evidence that Dr. Fitzgerald erroneously determined that Claimant had reached MMI. DIME physician Dr. Fitzgerald concluded that Claimant had not reached MMI because he required the following: (1) a shoulder arthrodesis assessment, (2) a mental health evaluation, and (3) nerve pain medication. However, the record reveals that the preceding treatments constitute medical maintenance treatment or have already been completed. Initially, Dr. Hatzadakis performed a shoulder arthrodesis assessment on Claimant, did not recommend the procedure and determined that Claimant had reached MMI. Second, Claimant underwent a psychiatric independent medical examination with Dr.

Kleinman. Claimant told Dr. Kleinman that he was not interested in medication adjustments or psychological treatment. Dr. Kleinman thus concluded that Claimant had reached MMI from a mental health perspective. Finally, Dr. Ring persuasively explained that nerve pain medication is not an appropriate form of treatment for Claimant's injury, any further changes in Claimant's medication regimen would constitute medical maintenance care and none of the physicians who treated Claimant after August 23, 2007 had prescribed nerve pain medication. Notably, Dr. Abbott also commented that prescriptions for nerve pain medication would constitute medical maintenance treatment.

9. As found, Respondents have also demonstrated by a preponderance of the evidence that Dr. Fitzgerald erroneously assigned Claimant a 44% upper extremity impairment rating. The impairment rating consisted of 23% for range of motion loss and 27% for a brachial plexus nerve injury. Dr. Fitzgerald commented that Claimant's EMG results were "not in a pattern that would be consistent with brachial plexopathy." Nevertheless, Dr. Fitzgerald assigned Claimant an impairment rating for a brachial plexus nerve injury based on Ms. Gerig's observations. However, Dr. Ring persuasively concluded that Claimant did not suffer a brachial plexus injury. He explained that an EMG is the "gold standard" and best test to determine whether a brachial plexus injury exists. Claimant's EMG results and activities in the surveillance video are inconsistent with a brachial plexus injury. Furthermore, Dr. Clinkscales remarked that a consultation with a brachial plexus specialist was unnecessary because of Claimant's normal EMG. Claimant is thus entitled to a 23% left upper extremity impairment for range of motion loss.

Peripheral Nerve Stimulator Trial

10. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). The determination of whether a particular treatment modality is reasonable and necessary to treat an industrial injury is a factual determination for the ALJ. *In re of Parker*, W.C. No. 4-517-537 (ICAP, May 31, 2006); *In re Frazier,* W.C. No. 3-920-202 (ICAP, Nov. 13, 2000). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

11. As found, Claimant has failed to demonstrate by a preponderance of the evidence that a peripheral nerve stimulator trial constitutes reasonable and necessary medical treatment designed to cure and relieve the effects of his industrial injury. Initially, Dr. Fitzgerald did not recommend a peripheral nerve stimulator assessment. Dr. Ring recommended against a peripheral nerve stimulator trial because there was no evidence that Claimant sustained a brachial plexus injury and his symptoms were most likely caused by mechanical shoulder pain. He explained that peripheral nerve stimulators are not approved by the FDA and are not an accepted form of treatment for Claimant's mechanical shoulder pain, carpal tunnel syndrome and cubital tunnel syndrome. Finally, doctors Raschbacher and Hattem reviewed Claimant's medical records and de-

termined that a nerve stimulator trial was not warranted. In contrast, Dr. Barolat did not adequately address how Claimant's nerve symptoms were caused by a brachial plexus injury despite a normal EMG.

Overpayment

12. An "overpayment" includes money received by a claimant that exceeds the amount that should have been paid or that the claimant was not entitled to receive. §8-40-201(15.5), C.R.S. Respondents have the burden of proving an entitlement to recover an overpayment. *Rocky Mountain Cardiology v. ICAO,* 94 P.3d 1182, 1186 (Colo. App. 2004). In 1997 the General Assembly amended §8-43-303 to permit reopening on the basis of "fraud" or "overpayment." *In Re Simpson,* W.C. No. 4-467-097 (ICAP, Aug. 8, 2007). Moreover, the statute provides that reopening may not "affect moneys already paid except in cases of fraud or overpayment." *Id.* Consequently, the statute contemplates that in cases involving an overpayment, the ALJ "has authority to remedy the situation." *In Re Moran-Butler,* W.C. No. 4-424-488 (ICAP, Aug. 21, 2008); *In Re Simpson,* W.C. No. 4-467-097 (ICAP, Aug. 8, 2007).

13. As found, Respondents have established by a preponderance of the evidence that they are entitled to recover an overpayment from Claimant. Ms. Cooper credibly explained that Insurer has already paid Claimant for all of the indemnity benefits referenced in its October 11, 2007 FAL. Insurer has not yet taken an SSDI offset against any of the indemnity benefits paid to Claimant for the period August 1, 2006 through April 23, 2009. Ms. Cooper noted that Insurer made an error or mistake when it failed to claim the offset in the FAL. The overpayment totaled $20,525.98 based on a 40% extremity impairment rating. Claimant's SSDI offset rate was $144.40 per week. Respondents may recover thus recover an overpayment in an amount based on this Order at the rate of $144.40 each week.

Disfigurement

14. Section 8-42-108, C.R.S. provides that a claimant may obtain additional compensation if he is seriously disfigured as the result of an industrial injury. As found, Claimant has two three-inch scars on the back of his left shoulder as a result of his multiple surgeries. He also has one round scar slightly smaller than a dime in the same area. Claimant's whole left clavicle and shoulder area from neck to shoulder is unnaturally elevated from the effects of the February 1, 2005 industrial injury. Claimant is thus entitled to a disfigurement award in the amount of $2,000.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant reached MMI on August 23, 2007.

2. Claimant is entitled to a 23% left upper extremity impairment rating.

3. Claimant's request for a peripheral nerve stimulator trial is denied.

4. Respondents are entitled to recover an overpayment in an amount based on this Order at the rate of $144.40 each week.

5. Claimant is entitled to a disfigurement award in the amount of $2,000.

6. Any issues not resolved in this Order are reserved for future determination.

DATED: October 28, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-505-189

ISSUE

The sole issue to be determined by this decision concerns medical benefits, specifically, mileage reimbursement for travel expenses incurred for travel to treating physicians and to pick up prescription medications.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. This claim involves an admitted industrial injury of February 7, 2001, and is under a General Admission of Liability (GAL) filed on April 26, 2007.

2. Between November 12, 2008, and February 25, 2009, Claimant actually traveled three-thousand, two-hundred and thirty-five (3, 235) miles to obtain medical treatment and to pick up prescriptions from pharmacies located in the Loveland, Colorado, area.

3. Between February 26, 2009, and July 29, 2009, Claimant actually traveled two thousand, two-hundred and thirty-three miles (2, 233) to obtain medical treatment and prescriptions from pharmacies located in the Loveland, Colorado, area.

4. At hearing, Respondents argued that Claimant was not entitled to actual mileage incurred for traveling to and from the providers and pharmacies, but should be paid mileage as calculated by "MapQuest" (hereinafter the so-called "MapQuest Rate").

5. On February 25, 2009, Claimant submitted mileage reimbursement for the miles traveled between November 12, 2008, and February 25, 2009, requesting reimbursement in the amount of $1,294.00.

6. On March 20, 2009, Claimant was paid only $1,017.20, a difference of $276.80.

7. With Claimant's check, Respondents outlined their concerns with regard to Claimant's February 25, 2009, mileage request setting forth:

I've ran (*sic*) your client's mileage against the reported by MapQuest (enclosed). In many cases, your client seems to be overstating the amount of miles it takes to get from his home to the various physicians and pharmacies. I also found a few trips to the pharmacy that we do not have a corresponding bill. I have deleted these from the overall trip mileage.

8. On April 23, 2009, Claimant responded to Respondents' rejection of his mileage request setting forth:

First, you rely upon Mapquest to deny [Claimant's] mileage stating that he is overstating the amount of miles it takes to get from his home to various physicians' offices and pharmacies. We note that the Mapquest you are using is reflecting that the [Claimant and his family] live on the frontage road when, in fact, their home is not on the road but is back some distance from the road. Although the address is on the frontage road the driveway to get to the home has to go around a trucking company's property and, therefore, that is one part of your Mapquest, which is incorrect.

Additionally, my client has actually clocked the mileage on his odometer and Mapquest is incorrect with regard to mileage. He will testify to these issues at hearing.

* * *

Next, you make the allegation that my client has made trips to the pharmacy for which you do not have corresponding medical bills. Often he goes to the pharmacy to pick up medication only to be told that your company has not authorized the prescribed medication.

9. At hearing, Claimant testified that prior to every trip to his authorized treating doctors, and to the pharmacy to pick up prescriptions, he pushes his trip odometer to zero. After making the round trip, he writes the mileage immediately down in a log he keeps in his car. That log is transferred to the mileage submissions

he makes. Claimant further testified that he does not always follow the MapQuest route if there are delays in traffic and that the MapQuest route is not, in fact, accurate. The ALJ finds that the Claimant presented and testified credibly because his testimony is consistent with reason and common sense, and it was not impeached in any way.

10. The adjuster testified that MapQuest was not run from Claimant's home, which is an RV in a 96 space RV park but, rather, from the generic address of the RV park. The adjuster does not know what route Claimant actually took to his doctors and pharmacies, as she was not in his car when he made his visits. While credible, the adjuster lacks a sufficient basis or foundation to dispute the Claimant's testimony concerning his actual mileage.

11. On August 6, 2009, Claimant submitted a second mileage request for mileage traveled between February 26, 2009, and July 29, 2009. Claimant requests reimbursement of $1,228.15. That mileage has not yet been paid.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions; the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). As found, the Claimant's testimony was consistent with reason and common sense, it was credible and it supports the actual mileage he claims. On the other hand, the adjuster's mechanistic use of MapQuest, without regard to Claimant's actual mileage was not reasonable because there is nothing in the statutes or rules that mentions MapQuest. On the contrary, the statutes and rules imply reimbursement for "actual" mileage as long as the mileage is not unreasonable.

b. Respondents argue that Claimant is not entitled to mileage reimbursements for his actual miles traveling to doctor visits and to obtain prescription medications pursuant to Workers' Compensation Rules of Procedure (WCRP), Rule 18-6 (E), 7 CCR 1101-3, but rather that Claimant is only entitled to the MapQuest miles. The ALJ is not persuaded by this argument.

c. WCRP, Rule 18-6 (E), 7 CCR 1101-3, provides for reimbursement for reasonable and necessary medical expenses for travel to and from medical appointments and to obtain prescribed medications.

d. The holding in *Mitchell v. Valley Welding, Inc.,* W.C. No. 4-312-227 [Industrial Claim Appeals Office (ICAO), October 21, 1997] is instructive. In *Mitchell*, the ALJ denied Claimant's request to have Respondents pay for modification of a van. The ALJ found that Respondents have provided reliable transportation services for Claimant and further found that Respondents were "willing to make adequate arrangements to deliver the claimant's medications. . . ." In that case, the ICAO held:

[T]he respondents are liable for medical services and medical apparatus which are either medical in nature or "incidental" to obtaining medical treatment. § 8-42-101(1)(a), C.R.S. 1997; *County Squire Kennels v. Industrial Claim Appeals Office,* 899 P.2d 362 (Colo. App. 1995). An expense is "medical in nature" if it relieves the symptoms or effects of the injury and is directly related to the claimant's physical needs. *Bellone v. Industrial Claim Appeals Office*, 940 P.2d 1116, (Colo. App. 1997); *Hillen v. Tool King*, 851 P.2d 289 (Colo. App. 1993).

An expense is "incidental" to medical treatment if the expense "enables" the claimant to obtain treatment or is a "minor concomitant" of medical treatment. *Country Squire Kennels v. Industrial Claim Appeals Office, supra.*

e. In *Daughtry v. King Soopers, Inc.,* W.C. No. 3-837-001 (ICAO, January 17, 1996), an ALJ denied reimbursement for mileage expenses that the Claimant incurred to obtain medically prescribed drugs. In setting aside the ALJ's Order, ICAO expressly held that drugs prescribed by a physician are a form of medical "supply" which § 8-42-101(1)(a) requires Respondents to provide if reasonable and necessary to cure or relieve the effects of the industrial injury. Further, ICAO stated that they could "find no statutory basis for the ALJ's apparent distinction between travel for the purpose of obtaining treatment by a physician and travel for the purpose of obtaining drugs (or other therapy) prescribed by a physician." Moreover, citing *Industrial Commission v. Pacific Employers Insurance Co.,* 120 Colo. 373, 209 P.2d 908 (1949), *Sigman Meat Co. v. Industrial Claim Appeals Office*, 761 P.2d 265 (Colo. App. 1988), and *Country Squire Kennels v. Tarshis,* 899 P.2d 362 (Colo. App. 1995), the ICAO has previously held that mileage expenses incurred to obtain prescription drugs are compensable if "incident" to obtaining the prescribed drugs.

f. The *Daughtry* holding was reaffirmed in the matter of *Anderson v. United Airlines and Gallagher Bassett Services*, W.C. No. 4-445-052 (ICAO, January 9, 2004).

g. Additionally, insofar as the Respondents argue the mileage expenses are not reasonable and necessary because the Claimant could have procured the drugs during the shopping trips to his regular grocery store, the ALJ finds this argument unpersuasive. As noted above, the question of whether particular mileage expenses are

reasonable and necessary is a question of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192 (Colo. App. 2002).

h. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. (2008). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant has sustained his burden of proof by proving that the mileage he submitted on February 25, 2009, in the amount of 3, 235 miles was accurate and actually incurred. Claimant is entitled to a full payment of $1,294.00, less the previously paid amount of $1,017.20, resulting in an additional payment of $276.80. Also, as found, Claimant has proven that the mileage he submitted on August 6, 2009, in the amount of 2, 233 miles payable at the rate of $1,228.15 was actually incurred and should be paid.

ORDER

IT IS, THEREFORE, ORDERED THAT:

A. Respondents shall pay the Claimant $1,294.00 for mileage, less the previously paid amount of $1,017.20, resulting in an additional payment of $276.80, which is retroactively due and payable forthwith.

B. Respondents shall pay in full Claimant's mileage submission of August 6, 2009, in the amount of 2, 233 miles, in the amount of $1,228.15, which is retroactively due and payable forthwith.

C. Respondents shall pay the Claimant statutory interest at the rate of eight percent (8%) per annum on all amounts due and not paid when due.

D. Any and all issues not determined herein are reserved for future decision.

DATED this 29 day of October 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-724-999

ISSUES

The issues to be determined by this decision include:

1. Whether Claimant is permanently and totally disabled (PTD) and unable to earn wages in the same or other employment;

2. Whether Claimant has overcome the division independent medical examination (DIME) physician's determination with respect to permanent partial disability (PPD) benefits, by clear and convincing evidence;

3. Whether Claimant proved that his average weekly wage (AWW) should be increased;

4. Whether Claimant is entitled to a change of physician; and

5. Whether Respondent has overcome the DIME physician's determination with respect to permanent partial disability (PPD) benefits, by clear and convincing evidence.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. Claimant was born April 27, 1972 and is currently 37 years old.

2. Claimant worked as a Patrol Officer/Sheriff's Deputy from 1994 to 2007. His duties included work as a detention officer, work in community relations to promote safety, work with motor vehicle accidents and domestic disputes, conducting drug searches, investigations, and apprehensions.

3. Claimant has a history of non-work related back problems. In November of 2000 Dr. Sung evaluated Claimant for left back and buttock pain. An MRI dated June 22, 2006 revealed a large left posterior L5-S1 disk herniation, as well as a L4-5 disk herniation and facet degeneration at L3-4 and L5-S1. On July 6, 2006, Dr. Sung recommended a surgical discectomy for Claimant's low back problems. Claimant underwent a non-work related lumbar discectomy on July 18, 2006. Claimant was released back to work on October 3, 2006.

4. On October 13, 2006, Claimant was involved in a work related motor vehicle accident. Claimant went to Parkview Medical Center, where he was evaluated through x-rays of the lumbar spine and released. He was given Vicodin for pain control.

5. Dr. Sung evaluated Claimant on November 1, 2006. His impression was that of L4 through S1 disk degeneration and an L4-5 annular tear. Following treatment, Claimant was released to work without restrictions.

6. Dr. Bradley (Emergicare) placed Claimant at maximum medical improvement in January 2007, and released Claimant without any evidence of permanent impairment associated with the work injury. Respondent filed a Final Admission consistent with Dr. Bradley's determination.

7. Claimant objected to the Final Admission of Liability and began the Division IME process.

8. On March 15, 2007, Claimant returned to Emergicare complaining of increased low back pain. Dr. Sung evaluated Claimant on May 31, 2007 and, following an MRI and discogram, ultimately recommended Claimant receive an L4 through S1 anterior fusion.

9. Dr. Sandell performed the DIME on November 22, 2007. Dr. Sandell reported that Claimant was not at maximum medical improvement based on Claimant's worsening of condition and that another surgery may be appropriate. Dr. Sandell rated Claimant with a 25% whole person impairment. At that time he did not apportion Claimant's prior non-work related back surgery, but noted that "I would addendum this impairment if further information becomes available. If there is any information regarding his pre-accident ROM, that would then be apportioned."

10. Respondent authorized the lumbar fusion recommended by Dr. Sung and Claimant underwent a lumbar fusion on January 14, 2008. Claimant reported improvement with the surgery, particularly with reduction in nerve pain.

11. Dr. Bradley placed Claimant again at maximum medical improvement on October 2, 2008.

12. On December 8, 2008, a follow up DIME with Dr. Sandell occurred. Dr. Sandell agreed with Dr. Bradley that Claimant reached maximum medical improvement on October 2, 2008. He rated Claimant with a 23% whole person impairment. He noted that "I do feel there is an issue of apportionment regarding the ROM. Therefore, I used the worksheets for evaluation and ROM deficits from a previous spinal injury. This provided a 3% ROM impairment due to previous injury. Therefore, 13% minus 3% equals a 10% whole person impairment for ROM as it relates to this injury."

13. Respondent filed a Final Admission on March 5, 2009 consistent with Dr. Sandell's report.

14. On April 6, 2009, Claimant objected to the Final Admission and filed an Application for Hearing. Hearing in this matter took place on July 16, 2009.

15. Claimant testified at hearing. He is 37 years old. He admitted that he participates in a multitude of physical activities and is independent and functional: he vacuums; he mows the yard, uses a Bowflex machine regularly, prepares meals, uses an air brush to paint, grocery shops, and prepares meals for his family.

16. At hearing Claimant admitted that he was featured in a newspaper article in the Pueblo West View, published September 25, 2008. The September 25, 2008 article publicized Claimant's ownership in a business, which was recently started with his wife, called "Massage and Body Works." Claimant admitted he is the owner of "Massage and Body Works" and that he is a licensed massage therapist.

17. Claimant testified that he used to own and operate a video rental business called Santa Fe Video. Claimant is the registered agent for Santa Fe Video, LLC.

18. Claimant's interrogatory responses, signed under oath, failed to disclose his ownership in Massage and Body Works or the fact that he is a licensed massage therapist. Claimant's interrogatory responses, signed under oath, further failed to disclose that he owned and operated a video rental store, Santa Fe Video, LLC. At hearing Claimant testified that "he did not know why" he failed to disclose this employment history and educational history. I did not find Claimant's testimony credible.

19. Ms. Torrey Beil, Respondent's vocational expert, prepared a report and also testified at hearing. She concluded that Claimant is able to return to light work and earn wages. Ms. Beil based her conclusion on all of the medical records, Claimant's permanent work restrictions of no lifting greater than 30 pounds, her interview of Claimant, his history of prior employment and education.

20. Ms. Beil testified that Claimant did not reveal, during her vocational interview/assessment with the Claimant, the fact that he owned Massage and Body Works. She testified that Claimant was not forthcoming about his former ownership in a video rental business, Santa Fe Video, LLC. Ms. Beil also testified that Claimant did not disclose that he was a licensed massage therapist.

21. Ms. Beil testified that she relies on Claimant's subjective reporting of his employment and educational history to perform a vocational assessment. Ms. Beil testified that if someone withholds information regarding their employment and educational background, it hinders her ability to identify transferable skills and conduct appropriate labor market research.

22. Based on the information she was provided by Claimant and her records review, Ms. Beil still identified the positions of: a.) video rental clerk; b.) private investigator; and c.) sales clerk, as appropriate positions for Claimant given his skill set and permanent work restrictions. She testified that the three specific positions identified as suitable for Claimant were a sample of what positions were available. Ms. Beil noted that the job positions she identified was not meant to be an exhausting list, but rather a representative sampling, of

what positions were available for Claimant. I find Ms. Beil's testimony regarding the availability of suitable employment positions credible and persuasive.

23. Dr. Bradley, Claimant's treating physician, found Claimant medically approved to work in the positions of video rental clerk, private investigator, and sales clerk. Dr. Primack, who performed an Independent Medical Examination on Claimant previously, also found Claimant medically approved to work in the positions of video rental clerk, private investigator, and sales clerk. I found Dr. Bradley's and Dr. Primack's testimony regarding this issue credible.

24. Prior to commencement of the hearing, due to that fact that Dr. Sandell was unable to attend and had been properly served a subpoena, Claimant was permitted to take the post hearing deposition of Dr. Sandell.

25. Dr. Sandell testified that he apportioned range of motion due to Claimant's history of non-work related back problems. He used the Division's worksheets for apportionment and detailed the step by step procedure he used in support of apportionment.

26. Dr. Sandell did not apportion at the time of his initial evaluation because "I wasn't as concerned about the issue of apportionment, because I had already stated I didn't feel he was at MMI. Even though the Division requires we provide an impairment rating, even if we say they're not at MMI, I think, ultimately the impairment needs to be applied when they are at MMI." In the first DIME appointment, Dr. Sandell did not use the Division apportionment worksheets because Claimant was not yet at MMI.

27. Dr. Sandell considered Claimant's hernia but chose not to rate because it was treated and resolved. "I did not provide any impairment for the hernia. I was aware of the history. It was my understanding, this was treated and addressed, and he was not complaining of any ongoing problems with his hernia."

28. Claimant testified that he thought he would receive a 3% raise annually. The ALJ does not find this to be persuasive on the issue.

29. , Dr. Sandell testified that Claimant's treatment for his work related injury was reasonable and appropriate and Dr. Sandell did not see any indication that a change of physician was appropriate. The evidence does not warrant a change of physician.

CONCLUSIONS OF LAW

1. When determining credibility, the fact finder should consider, among other things, the consistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability and improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Prudential Insurance Company v. Cline*, 57 P.2d 1205 (Colo. 1936); CJS, Civil 3:16 (2005).

2. To establish a permanent total disability, Claimant must demonstrate by a preponderance of the evidence that he is unable to earn wages in the same or other employment. C.R.S. §8-43-201; C.R.S. §8-40-201(16.5)(a).

3. Claimant failed to establish that he is unable to earn wages in the same or other employment by a preponderance of evidence. Instead, the evidence revealed that Claimant has transferable skills, a strong work history and that Claimant is currently working in his business Massage and Body Works. Further, Ms. Beil's testimony was persuasive and identified multiple employment positions that are reasonably available to Claimant. In addition, Dr. Bradley and Dr. Primack found Claimant medically approved to work in these positions. Based upon a totality of the evidence presented, accounting for appropriate credibility determinations, the ALJ concludes that the Claimant has failed to establish that it is more likely than not that he is PTD.

4. The findings of a Division-sponsored independent medical evaluator shall only be overcome by clear and convincing evidence. C.R.S. §8-42-107(8). Apportionment of medical impairment, as opposed to "disability," is an issue for determination by the DIME physician and the DIME physician's apportionment is binding unless overcome by clear and convincing evidence. *See McClure v. Stresscon Corp.*, W.C. No. 4-442-919 (ICAO May 17, 2001). Clear and convincing evidence is highly probable and free from serious or substantial doubt and the party challenging the DIME physician's findings must present evidence showing it highly probably that the DIME physician is incorrect. *Metro Moving & Storage Company v. Gussard,* 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and convincing evidence if, after considering all of the evidence, the trier of fact finds it to be highly probable and free from serious or substantial doubt. *Id*. A mere difference of opinion between physicians fails to constitute error. *See Gonzales v. Browning Farris Industry of Colorado*, W.C. No. 4-350-36 (ICAO March 22, 2000).

5. Neither Claimant nor Respondent was successful in overcoming Dr. Sandell's division IME findings. Dr. Sandell's opinion was legitimately based on medical evidence and Dr. Sandell appropriately utilized the Division worksheets regarding apportionment. Based upon a totality of the evidence presented, accounting for appropriate credibility determinations, the ALJ concludes that the Claimant and Respondent failed to establish that the opinion of the DIME physician is clearly erroneous as to the determination of Claimant's medical impairment and the issue of apportionment related thereto.

6. Average weekly wage (AWW) is generally determined based upon an employee's wage at the time of the injury. C.R.S. §8-40-201(19); C.R.S. §8-42-102. An employee has the burden of proving entitlement to benefits by a preponderance of the evidence. C.R.S. §8-43-201.

7. Claimant submitted no documents or wage records indicating he is entitled to an increase in AWW. Instead, he testified only that he thought he would receive a 3% raise annually. The evidence presented does not support an increase in AWW and Claimant failed to meet his burden of proof. Based upon a totality of the evidence presented, accounting for appropriate credibility determinations, the ALJ concludes that the Claimant has failed to establish that it is more likely than not that his AWW should be increased.

8. A claimant may seek a change of physician upon a "proper showing." C.R.S. §8-43-404(5); *Carlson v. Industrial Claim Appeals Office*, 950 P.2d 663 (Colo. App. 1997). Section 8-43-404(5) does not contain a specific definition of what constitutes a "proper

showing." Consequently, it has been held that the ALJ possesses broad discretionary authority to grant a change of physician depending on the particular circumstances of the claim. *See Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999) *Szocinski v. Powderhorn Coal Co.*, W.C. No. 3-109-400 (ICAO December 14, 1998); *Merrill v. Mulberry Inn, Inc.*, W.C. No. 3-949-781 (ICAO November 16, 1995). Mere dissatisfaction of the claimant with the physician or other personal reasons does not compel the ALJ to approve a change of physician. *Pohlod v. Colorado Springs School District No. 11*, W.C. No. 4-621-629 (ICAO May 2, 2007)(citing *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985)).

9. Claimant did not provide a proper showing as to why a change of physician is necessary under the present circumstances and his testimony demonstrated only mere dissatisfaction. In contrast, Dr. Sandell testified that Claimant's treatment for his work related injury was reasonable and appropriate and Dr. Sandell did not see any indication that a change of physician was appropriate. (Dr. Sandell P 47). The evidence simply does not warrant a change of physician. Based upon a totality of evidence presented, accounting for appropriate credibility determinations, the ALJ concludes that the Claimant has failed to establish that he is entitled to a change in physician.

ORDER

It is therefore ordered that:

1. Claimant's claim for PTD is denied and dismissed.

2. Claimant's claim for an increase in the PPD is denied and dismissed.

3. Claimant's claim for an increase in AWW is denied and dismissed.

4. Claimant's claim for a change of physician is denied and dismissed.

5. Respondent's claim for a decrease in PPD is denied and dismissed.

6. All matters not determined herein are reserved for future determination.

DATE: October 28, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-733-071

ISSUES

The issue to be determined by this Order is Claimant's entitlement to penalties against Respondent-Employer for failure to follow a previous Order issued October 28, 2008 by Administrative Law Judge Martin D. Stuber.

FINDINGS OF FACT

1. Respondent-Employer acknowledged receipt of ALJ Stuber's October 27, 2008 Order and knew or reasonably should have known of his obligation to post a bond or deposit the sum of $27,000.00 with the Division of Workers' Compensation especially when one considers the prior Order requesting Respondent-Employer to post/deposit the sum of $16,000.00 with the Division.

2. Respondent-Employer timely appealed the October 27, 2008 Order arguing that his insurance broker failed to supply all necessary paperwork to create a policy covering his employee against work-related injuries. Thus, Employer constructively was challenging his obligation to post and deposit the sum of $27,000.00. This constitutes further evidence that Respondent-Employer was aware of his obligation to make the necessary payment or post the Ordered bond.

3. The Industrial Claim Appeals panel perceived no basis upon which to interfere with the Order of ALJ Stuber dated October 27, 2008. Therefore, the Panel affirmed the Order and it became final as the Respondent-Employer did not appeal the Panel's decision further.

4. In addition to acknowledging receipt of the October 27, 2008 Order, Respondent-Employer testified that he received correspondence from the Department of Labor and Employment, Division of Workers' Compensation Special Funds Unit dated May 23, 2008 and November 12, 2008 advising Respondent-Employer that the trust deposit/ bond ordered had not been received. Respondent-Employer has made no effort to post the bond, deposit the trust amount and has not paid the Claimant directly any sum to cover the benefits ordered.

5. Respondent-Employer has willfully refused to post the bond and/or make payment to the Claimant, testifying that he had "no intention" of doing so.

6. Claimant testified that he has received no payments from Respondent-Employer for previously ordered temporary/permanent partial, and/or disfigurement benefits. Furthermore, Claimant testified that he has received no payment to compensate him for the penalties previously ordered by ALJ Stuber pursuant to his October 27, 2008 Order.

CONCLUSIONS OF LAW

Based upon the Findings of Fact, the ALJ makes the following Conclusions of Law:

1. Claimant seeks a penalty pursuant to Section 8-43-304(1), C.R.S. due to the Respondent-Employer's violation of the October 27, 2008 order to post a bond or deposit $27,000.00 within ten (10) days. Section 8-43-408(2), C.R.S., required the Judge in the October 27, 2008 order to require the Respondent-Employer to deposit monies or post a bond with the Division. The order required that deposit within ten (10) days. As found, the Respondent-Employer has intentionally failed to comply with the order.

2. Section 8-43-304(1), C.R.S. provides in pertinent part for penalties of up to $500.00 per day if the employer "violates any provision of articles 40 to 47 of this title, or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director or panel." Analysis of the penalty under section 8-43-304(1) is appropriate. *Holliday v. Bestop, Inc., 23 P.3d 700 (Colo. 2001)* ("Holliday II") held that the phrase "for which no penalty has been specifically provided" referred to the third category of violations, failing to perform a duty lawfully enjoined, but it did not refer to penalties for failure to obey a lawful order of the director or panel. *Pena v. Industrial Claim Appeals Office of the State of Colorado, 117 P.3d 84, (Colo.App.2004*) held that the limiting phrase applied to the first three categories, not just the third category. In any event, the fourth category, violating an order, subjects the violator to a possible penalty under section 8-43-304(1), C.R.S., even if other specific penalties may also be available. "Order" is defined in section 8-40-204(15), C.R.S. as including a rule: "Order" means and includes any decision, finding and award, direction, rule, regulation or other determination arrived at by the director or Administrative Law Judge." The ALJ concludes that the Respondent-Employer is liable for only one of the penalties for the same actions. The ALJ concludes that the most appropriate penalty hereunder involves the failure to obey the order of ALJ Stuber.

3. Under Section 8-43-304(1), Claimant must first prove that the disputed conduct constituted a violation of statute, rule, or order. *Allison v. Industrial Claims Appeals Office, 916 P.2d 623 (Colo. App. 1995); Villa v. Wayne Gomez Demolition & Excavating, Inc., W.C., No. 4-236-951 (ICAO, January 7, 1997)*. Second, if the employer committed a violation, penalties may be imposed only if the employer's actions were not reasonable under an objective standard. *Pioneers Hospital of Rio Blanco County v. Industrial Claims Appeals Office, 114 P.3d 97 (Colo. App. 2005); Jiminez v. Industrial Claim Appeals Office, 107 P.3d 965 (Colo. App. 2003); Pueblo School District No. 70 v. Toth, 924 P.2d 1094 (Colo. App. 1996)*. The standard is "an objective standard measured by the reasonableness of the insurer's action and does not require knowledge that the conduct was unreasonable." *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office, 907 P.2d 676, (Colo. App. 1995)*.

4. As found, the Respondent-Employer failed to deposit sums or file a bond with the Division, as ordered in the October 27, 2008 order. As found, the employer had no rea-

sonable basis for the violation. The penalties hereunder commence on November 7, 2008 and continue until paid. Each day of violation is a separate violation.

5. Section 8-43-304, C.R.S. requires imposition of a penalty of at least one cent per day for the employer's unreasonable violation of the order commencing November 7, 2008. *Marple v. Sait Joseph Hospital, W.C., No. 3-966-344 (Industrial Claim Appeals Office, September 15, 1995*) (decided under predecessor Section 8-53-116). All of the circumstances must be considered in determining the amount. The amount of the penalty should be sufficient to dissuade a violator from future violations, but should not be constitutionally excessive or grossly disproportionate to the violation found. The ALJ should consider the reprehensibility of the conduct involved, the harm to the non-violating party and the difference between the amount of the penalty and civil damages that could be imposed in comparable cases. *Associated Business Products v. Industrial Claim Appeals Office, 126 P.3d 323 (Colo. App. 2005)*.

6. Considering the nature of the violation, (a repeat violation of a failure to submit sums ordered to be paid or post a bond) and Respondent-Employer's insistence that he has no intention of paying the ordered sums or posting the bond, as well as the Claimant's continuing need for benefits, the ALJ concludes that the previously ordered $20.00 per day penalty was insufficient to dissuade the violator from future violations. The Judge concludes that a penalty of $25.00 per day is appropriate for 306 days of violation up to the hearing in this matter.

7. Pursuant to Section 8-43-408(2), C.R.S., the Respondent-Employer is required to post a bond or deposit additional monies to cover the amount of penalties in the current order, in the total amount of $7,650.00.

ORDER

It is therefore ordered that:

1. The Respondent-Employer shall pay a penalty in the amount of $7,650.00. The Respondent-Employer shall pay 75% of the penalty to the Claimant as the aggrieved party and 25% to the Subsequent Injury Fund.

2. The Respondent-Employer shall pay interest to Claimant at the statutory interest rate of eight percent (8%) on all amounts of compensation not paid when due.

3. The Respondent-Employer shall:

a. Deposit the sum of $7,650.00 with the trustee, Subsequent Injury Fund Unit of the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: SS, to secure the payment of all unpaid compensation and benefits awarded, or in lieu thereof,

b. File a bond in the sum of $7,650.00 with the Division of Workers' Compensation within ten (10) days of the date of this order:

(1) Signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation or

(2) Issued by a surety company authorized to do business in Colorado.

(3) The bond shall guarantee payment of the compensation and benefits awarded.

4. IT IS FURTHER ORDERED: That the Respondent shall notify the Division of Workers' Compensation of payments made pursuant to this order.

5. IT IS FURTHER ORDERED: That the filing of any appeal, including a petition for review, shall not relieve the Respondent of the obligation to pay the designated sum to a trustee or to file the bond. Section 8-43-408(2) C.R.S.

6. This order does not relieve the Respondent-Employer from the obligations imposed by all previous orders in this matter.

7. All matters not determined herein are reserved for future determination.

DATE: October 28, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-795-810

ISSUES

The issues to be determined by this decision concern compensability and, if compensable, medical benefits.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. The Employer employed the Claimant in its logistics department. On May 11, 2009, the Claimant reported to work at approximately 4:00 AM. At approximately 11:30 AM, he stated that he was stocking. While walking across the floor, his left knee buckled when his foot allegedly caught on the linoleum. As found below, Claimant did

not mention the alleged "catching of his foot on linoleum" until his testimony at the hearing. The ALJ does not find the alleged "foot catching on linoleum" testimony credible because it is inconsistent with Claimant's previous contemporaneous statements in which there was no mention of this allegation. The Claimant reported to his supervisor, Pil Kim, that he was having a problem with his knee and did not mention the alleged "foot catching on linoleum."

2. The Claimant's left knee progressively worsened on the date of the incident, and he went to Kaiser Permanente at approximately 3:00 PM. The medical report from Kaiser indicates that the Claimant was prescribed a knee brace and told to take Ibuprofen. He was also told to stay off of his feet as much as possible. While at Kaiser Permanente, the Claimant filled out an Accident/Insurance Information Sheet. On that form, he stated his knee "just kind of buckled" while he was walking along at work. There was no mention of the alleged "foot catching on linoleum."

3. After reporting his medical restrictions to his supervisor, the Claimant was then placed on modified duty. The Claimant did not work on May 12, 2009, but then continued to work for the Employer until he resigned, on or about September 25, 2009, to take a new job.

4. Pil Kim stated that on May 11, 2009 the Claimant came to him indicating that he was having problems with his knee and Claimant jokingly stated that he "must be getting older." Kim stated that the Claimant did not indicate that his injuries were as the result of a work-related event, and Claimant did not mention his alleged foot sticking or getting caught on the linoleum. Over the next several weeks, Kim periodically asked Claimant how he was doing and at no time did the Claimant indicate to him that the problems with his knee were related to any work-related event.

5. On June 12, 2009, the Claimant went to Tirrell who works in the Employer's Human Resources Department. He indicated that his doctor at Kaiser Permanente had indicated that his knee problems were work-related and he asked to be referred to a physician. Tirrell asked the Claimant how he was injured and the Claimant stated that he was walking around the store and his left knee kind of buckled while he was walking at approximately 11:30 AM. Tirrell then filled out a Team Incident Summary setting forth that the Claimant's injuries had occurred when he was walking along and his knee kind of buckled while he was walking alone at work. Tirrell read the description of the injury back to the Claimant and the Claimant indicated that it accurately described how he was hurt. The meeting with Tirrell on June 12, 2009 was the first time the Claimant advised any representative of the Employer that his knee injury may have been work-related. At the time, Claimant believed that it was work-related simply because it happened during his working hours at the Employer's work site. There was no mention of the foot allegedly "catching on linoleum."

6. While at Kaiser Permanente on May 11, 2009, the Claimant was seen by Richard A. Albu, Physician's Assistant (PA). PA Albu referred the Claimant to an orthopedic surgeon, Darin W. Allred, M.D. Dr. Allred suggested to the Claimant that they

monitor his knee problems for several weeks and it was possible that he would eventually need surgery. The Claimant has not returned to a physician since he saw Dr. Allred on June 2, 2009.

7. Claimant's walking on the floor at work involves a ubiquitous situation and there is no special hazard connected therewith. Therefore, the Claimant has not established a special hazard connecting the circumstances of his employment with his left knee condition.

8. The Claimant continues to have problems with his knee. The doctors have advised him that he may need surgery.

9. The Claimant has failed to prove, by a preponderance of the evidence that he sustained a compensable left knee injury on May 11, 2009, arising out of the course and scope of his employment and proximately caused by a special hazard of that employment.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions; the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Prudential ins. Co. v. Cline,* 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). As found, the Claimant's late disclosure at hearing that his left foot allegedly caught in linoleum is not credible because it is inconsistent with his previous, contemporaneous nondisclosure of this factor. Without this factor, there is no special hazard of employment proximately causing his left knee condition. The buckling thereof is then an idiopatchic or syncopal event.

b. In order for an injury to be compensable under the Workers' Compensation Act, it must "arise out of" and "occur within the course and scope" of the employment. *Price v. Industrial Claim Appeals Office,* 919 P.2d 207, 210, 210 (Colo. 1996). There is no presumption that an injury arises out of employment when an unexplained injury occurs during the course of employment. *Finn v. Industrial Comm'n,* 165 Colo. 106, 108-09, 4437 P.2d 542 (1968). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded. § 8-41-301 (1)(c) C.R.S. (2009). *See Faulkner v. Industrial Claim*

Appeals Office, supra. The question of causation is generally one of fact for the determination by the ALJ. *Faulkner* at 846. As found, the Claimant has failed to establish causation.

c. An unexplained fall resulting in a fatal head injury, caused by the claimant hitting his head on the concrete floor, was determined to lack a causal connection between the injury and the employment. The court reasoned that the concrete floor was "a ubiquitous condition" and not a special hazard of employment. *Gates Rubber Co. v. Industrial Commission,* 705 P.2d 6 (Colo. App. 1985). *Also see Horne v. St. Mary-Corwin Hospital,* W.C. No. 4-205-014 [Industrial Claim Appeals Office (ICAO), April 14, 1995] [holding that an injury when arising from a stool at work did not involve a "special hazard of employment" because arising from a stool involved an "ubiquitous condition." Some injuries, however, resulting from idiopathic conditions are compensable if the conditions or circumstances of the employment **contribute** to the injuries. *See National Health Laboratories v. Industrial Claim Appeals Office,* 844 P.2d 1259 (Colo. App. 1992). Working at heights is considered a "special hazard" even if the employee falls because of an unknown reason or because of the idiopathic condition. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989). In the present case, as found, walking on the floor at work involves a ubiquitous situation and there is no special hazard connected therewith.

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d. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing the compensability of an industrial injury and entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. (2009). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Claimant has failed to sustain his burden of proof with respect to compensability.

ORDER

IT IS, THEREFORE, ORDERED THAT:

Any and all claims for workers' compensation benefits are hereby denied and dismissed.

DATED 29 October 2009.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-782-746

ISSUES

Hearing was held on the Respondents' application, which sought to withdraw their general admission of liability, asserting that the claim was not compensable, asserting that the general admission was filed based upon a fraud perpetrated by the Claimant. As such, the burden of proof to establish compensability rests with the Claimant. The burden of proof to establish the affirmative defense of fraud rests with the Respondents.

FINDINGS OF FACT

1. On Tuesday, January 20, 2009 Claimant was attending a required training class conducted by the Respondent-Employer.
2. During the training referred to as a "four man takedown" Claimant participated as the subject who was to be taken down.
3. The training involved four other employees who were being trained to take down the subject. The take down involves two individuals who each control one arm, one individual controlling the subject's head, with the other individual controlling the subject's feet. The training involves putting the suspect down on her knees in a slow and controlled manner and then lowering the rest of the body to the floor.
4. During this training Claimant was inadvertently dropped a short distance to the floor and injured her ribs. The incident did not draw any attention by other participants at the time; however, Claimant did inform her instructor Gary O. that she had hurt her chest. Gary O. commented to the Claimant at the end of the training that he felt there was no way she could have hurt herself.
5. Claimant did not report this as a workers' compensation injury initially because she felt it was too minor and that it would quickly resolve itself.
6. Claimant went to work the following day, Wednesday, January 21, 2009 but could only complete one-half of a shift. She told the Respondent-Employer of the injury. The day following that, Thursday, January 22, 2009, Claimant could not go to work due to her condition, that being pain in her chest. She called in to work to report the injury and to find out where she should go in order to see the workers' compensation medical personnel.
7. Claimant was seen on January 22, 2009, by CCOM in Canon City by Diane Alvies, a nurse practitioner.
8. The medical evidence indicates that Claimant's condition is work-related by history. The credible medical evidence does not question whether or not there is a cause other than work.
9. The date of the occurrence of the injury is supported by the Respondent-Insurer's Physician Advisor Dr. Zini, in a letter dated September 16, 2009, where he states that he reviewed the CAT scan of July 29, 2009 and finds there are healing fractures to the Claimant's ribs that suggest they are "six or more weeks old."
10. Mike A. is an employee of the Respondent-Employer who was also involved in the training exercise on January 20, 2009. Mike A. did not recall the Claimant being involved in an exercise where she participated as the subject in a takedown. He does not recall seeing the Claimant dropped. He did not become aware of the fact that the

Claimant filed a workers' compensation claim in this matter until a couple of months prior to the hearing herein on October 6, 2009.

11. The ALJ does not find Mike A.'s testimony to provide credible evidence based upon the fact that he remembers very little about the events on the training day; the fact that he did not need to remember those facts for any particular reason until several months later when he was informed of the Claimant's claim, at which time his memory had faded; the fact that Mike A.'s testimony was in direct contradiction with other Respondent-Employer witnesses who indicate that they did indeed participate in a four man take down exercise. Claimant's testimony on the events of the date of injury, to the extent that he provided any explicit facts, is therefore unreliable. The ALJ finds Mike A.'s testimony that he never knew of the Claimant to be dishonest is reliable.

12. The ALJ find Claimant to be credible and concludes that her statement of the facts is more reliable than the contrary evidence introduced.

13. Claimant sustained an injury to her ribs on January 20, 2009 that arose out of her employment with the Respondent-Employer and occurred in the course of that employment.

14. Claimant lost time off of work as a result of her work-related injury. Nurse Practitioner Alvies took claimant off work from January 22, 2009 to January 27, 2009. Claimant was released to go back to work with restrictions on January 27, 2009 by Physician Assistant Quackenbush but the Respondent-Employer could not accommodate the restrictions. Claimant was released to full duty on February 18, 2009, although she was still not at maximum medical improvement (MMI).

15. PA Quackenbush placed claimant at MMI on March 4, 2009, with no permanent impairment anticipated.

16. Claimant required medical treatment for the injury that is the responsibility of the Respondent-Insurer.

17. Claimant has established that it is more likely than not that she sustained a compensable work-related injury to her chest and ribs on January 20, 2009.

18. The ALJ finds that none of the actions engaged in by the Claimant in pursuing her claim involved the making of a willful false statement or misrepresentation material to the claim, and thus Respondents' have failed to establish that the Claimant engaged in fraud in pursuing her claim. Conversely, although not required, Claimant has established by a preponderance of the evidence that she did not engage in fraud.

CONCLUSIONS OF LAW

1. Claimant has the burden of proving a compensable injury and entitlement to benefits by a preponderance of the evidence. Sections 8-41-301 and 8-43-201, C.R.S. The Workers' Compensation Act of Colorado (WCA) has no "presumption of compensability"; instead, workers' compensation cases are to be decided on their merits. Section 8-43-201, C.R.S.; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). The question of whether a claimant has met the burden of proof is one of fact for determination by the ALJ. *Faulkner v. Industrial Claim Appeals Office, supra*, (threshold issue of compensability is question of fact for ALJ).

2. Ordinarily, “compensability” is the threshold issue in a WCA case. To establish a compensable claim, a claimant must establish that the alleged work injury or occupational disease arose out of and in the course of the claimant's employment or employment-related duties. Sections 8-41-301, C.R.S.; *see e.g. Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo.App. 2000). [Section 43-8-201, C.R.S. was amended by SB 09-168 by adding the language “a party seeking to modify an issue determined by a general or final admission, a summary order, or a full order shall bear the burden of proof for any such modification.” This amendment applies to claims filed on and after August 5, 2009. As the claim herein was filed prior to said date it is not applicable to the case hereunder. Thus, the burden of proof remains with the Claimant.]

3. Once a claimant has established a compensable work injury, the claimant is entitled to a general award of medical benefits and respondents are liable to provide all reasonable and necessary medical care to cure and relieve the effects of the work injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo.App. 1990). The obligation to provide treatment to "cure" or “improve” the claimant's condition terminates when a claimant reaches Maximum Medical Improvement (MMI).

4. In accordance with Section 8-43-215, C.R.S., this decision contains Specific Findings of Fact, Conclusions of Law, and an Order. In rendering this decision, the ALJ has made credibility determinations, drawn plausible inferences from the record, and resolved essential conflicts in the evidence. *See Davison v. Industrial Claim Appeals Office,* 84 P.3d 1023 (Colo. 2004). This decision does not specifically address every item contained in the record; instead, incredible or implausible testimony or unpersuasive arguable inferences have been implicitly rejected. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office,* 5 P.3d 385 (Colo. App. 2000).

5. The ALJ concludes that the Claimant has established by a preponderance of the evidence that she sustained a compensable work-related injury on January 20, 2009 and the Respondent-Insurer is liable for all appropriate workers’ compensation benefits flowing from this injury.

6. The ALJ concludes that the Respondents failed to establish by a preponderance of the evidence that the Claimant engaged in fraud in pursuing her claim. Conversely, although not required, Claimant has established by a preponderance of the evidence that she did not engage in fraud in pursuing her claim.

7. The ALJ concludes therefore, that the Respondent-Insurer’s request to withdraw the general admission of liability is denied and dismissed.

ORDER

It is therefore ordered that:

1. The Respondent-Insurer’s request to withdraw the general admission of liability is denied and dismissed.

2. The Respondent-Insurer shall continue to provide benefits in accordance with the general admission of liability until such time as they may terminate benefits by operation of law or order.

3. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
4. All matters not determined herein are reserved for future determination.

DATE: Ocotber 29, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-790-890

ISSUE

Whether Claimant has established by a preponderance of the evidence that he sustained a compensable occupational disease during the course and scope of his employment with Employer.

FINDINGS OF FACT

1. Claimant is a 60 year-old male. He worked for _ for 33 years as the supervisor of an auditing group. During his employment with _in August 2005 Claimant was diagnosed with Carpal Tunnel Syndrome (CTS) in both wrists. On September 27, 2005 he underwent a right carpal tunnel release. On October 18, 2005 Claimant underwent a left carpal tunnel decompression. On May 30, 2006 he reached Maximum Medical Improvement (MMI) and was released to regular employment.

2. In October 2005 Claimant retired from _. He then obtained employment with _ for approximately six months.

3. Claimant subsequently began employment with Employer as the Global Trade Compliance Manager. He apprised Employer that he had previously experienced CTS and thus obtained a modified workstation. Claimant's job duties primarily involved computer work consisting of keyboarding and writing.

4. On April 15, 2009 Employer terminated Claimant's employment because of economic downsizing. At his exit interview Claimant reported that he was experiencing pain in both wrists and recurrent CTS symptoms.

5. On July 27, 2009 Claimant underwent an independent medical examination with hand surgeon Jonathan L. Sollender, M.D. Dr. Sollender prepared a report and testified at the hearing in this matter. He remarked that Claimant's wrist symptoms had not improved since he had ceased employment with Employer. Dr. Sollender attributed Claimant's continued symptoms to home remodeling tasks that involved a "high degree of forcible gripping." He diagnosed Claimant with "[m]ild residual carpal tunnel syndrome" and persuasively concluded that Claimant's job duties while working for Em-

ployer did not cause his condition. Instead, Claimant's recurrent CTS constituted the natural progression of his pre-existing wrist condition.

6. Dr. Sollender discussed the CTS Medical Treatment Guidelines (Guidelines) produced by the DOWC. The CTS Guidelines were also admitted into evidence in this matter. He explained that the strongest risk factors associated with the development of CTS involved high exertional force and high repetition. Dr. Sollender also noted that metabolic conditions increase the likelihood of developing CTS. However, studies have demonstrated that there is insufficient or conflicting evidence about whether keyboarding is a risk factor for developing CTS.

7. Dr. Sollender testified that Claimant's current wrist symptoms are consistent with the symptoms for which he obtained treatment during 2005-2006. He noted that Claimant's present wrist symptoms would exist whether or not he had worked for Employer. Dr. Sollender also noted that Claimant's current right thumb complaints were "well documented in the postoperative note" and have "not changed dramatically." Based on a review of the medical records Dr. Sollender stated that Claimant's physical abilities have not changed since 2005.

8. Claimant testified at the hearing in this matter. He explained that his duties for Employer involved extensive research and report generation that required significant keyboarding. His responsibilities for Employer were similar to his activities while working for Hewlett Packard. Claimant remarked that he obtained a modified workstation when he began employment with Employer because he was still experiencing CTS. He acknowledged that he engaged in a number of household projects and used a variety of tools.

9. Claimant has failed to establish that it is more probably true than not that he sustained an occupational disease during the course and scope of his employment with Employer. Claimant's CTS was not caused, accelerated, intensified or aggravated by his duties for Employer. While working for _in August 2005 Claimant was diagnosed with CTS in both wrists. He subsequently underwent surgery on each wrist and reached MMI on May 30, 2006. After conducting an independent medical examination Dr. Sollender diagnosed Claimant with mild residual CTS and persuasively concluded that Claimant's job duties while working for Employer did not cause his condition. Instead, Claimant's recurrent CTS constituted the natural progression of his pre-existing wrist condition. Dr. Sollender testified that Claimant's current wrist symptoms are consistent with the symptoms for which he obtained treatment during 2005-2006. He also remarked that Claimant's wrist symptoms had not improved since he had ceased employment with Employer. Dr. Sollender attributed Claimant's continued symptoms to home remodeling tasks that involved a "high degree of forcible gripping." Furthermore, relying on the Guidelines, Dr. Sollender credibly explained that Claimant's keyboarding duties were insufficient to cause CTS. He noted that studies have demonstrated that there is insufficient or conflicting evidence about whether keyboarding is a risk factor for developing CTS. Therefore, Claimant's CTS cannot be fairly traced as a proximate cause to his employment with Employer.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. The test for distinguishing between and accidental injury and an occupational disease is whether the injury can be traced to a particular time, place and cause. *Campbell v. IBM Corp.*, 867 P.2d 77, 81 (Colo. App. 1993). "Occupational disease" is defined by §8-40-201(14), C.R.S. as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a haz-

ard to which the worker would have been equally exposed outside of the employment.

6. A claimant is required to prove by a preponderance of the evidence that the alleged occupational disease was directly or proximately caused by the employment or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office,* 989 P.2d 251, 252 (Colo. App. 1999). Moreover, §8-40-201(14), C.R.S. imposes proof requirements in addition to those required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819, 824 (Colo. 1993). A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.*

7. As found, Claimant has failed to establish by a preponderance of the evidence that he sustained an occupational disease during the course and scope of his employment with Employer. Claimant's CTS was not caused, accelerated, intensified or aggravated by his duties for Employer. While working for _in August 2005 Claimant was diagnosed with CTS in both wrists. He subsequently underwent surgery on each wrist and reached MMI on May 30, 2006. After conducting an independent medical examination Dr. Sollender diagnosed Claimant with mild residual CTS and persuasively concluded that Claimant's job duties while working for Employer did not cause his condition. Instead, Claimant's recurrent CTS constituted the natural progression of his pre-existing wrist condition. Dr. Sollender testified that Claimant's current wrist symptoms are consistent with the symptoms for which he obtained treatment during 2005-2006. He also remarked that Claimant's wrist symptoms had not improved since he had ceased employment with Employer. Dr. Sollender attributed Claimant's continued symptoms to home remodeling tasks that involved a "high degree of forcible gripping." Furthermore, relying on the Guidelines, Dr. Sollender credibly explained that Claimant's keyboarding duties were insufficient to cause CTS. He noted that studies have demonstrated that there is insufficient or conflicting evidence about whether keyboarding is a risk factor for developing CTS. Therefore, Claimant's CTS cannot be fairly traced as a proximate cause to his employment with Employer.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request for Worker's Compensation benefits is denied and dismissed.

DATED: October 29, 2009.

Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-794-575

ISSUES

Whether the Claimant sustained a compensable occupational disease injury to her bilateral thumbs arising out of and in the course of her employment with Employer.

If compensable, whether Claimant is entitled to medical benefits to cure and relieve the effects of her injury.

If compensable, whether Claimant is entitled to TPD benefits from December 18, 2008 and continuing.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant has worked for Employer as a dental hygienist for 23 years, beginning her employment in 1986. Claimant has held the same job throughout her employment with Employer.

2. When Claimant initially began work with Employer she worked 3 days per week. Claimant's work schedule was later modified to 2 day per week each week, with an additional day of work every other week.

3. Claimant began noticing subtle symptoms at the base of her thumbs in 2004 or 2005 that gradually became worse.

4. Claimant initially sought treatment with her personal physicians at Kaiser on August 22, 2005 when she was evaluated by Dr. Jeffery Morse. Dr. Morse obtained a history that Claimant had bilateral thumb pain and worked as a dental hygienist. Dr. Morse ordered bilateral hand and wrist X-rays that were interpreted as showing early/mild osteoarthritic change at the bilateral scaphotrapezoid joints and also involving the first carpometacarpal joints. Dr. Morse referred Claimant for physical therapy and Claimant was fitted for bilateral thumb spica splints.

5. Claimant returned to Dr. Morse for evaluation on September 25, 2008. Dr. Morse obtained a further history that Claimant had been having ongoing pain in her right greater than left hands for 3 years. Dr. Morse again noted that Claimant worked as a dental hygienist and also that Claimant felt she was losing strength in her hands. Dr. Morse ordered updated X-rays of the hands and wrists and referred Claimant to a hand specialist in orthopedics. The results of the X-rays showed bilateral triscaphe osteoarthritis slightly more prominent on the right.

6. Claimant was evaluated by Dr. Bristow, M.D. at Kaiser on October 7, 2008. Dr. Bristow noted a history that Claimant worked as a dental hygienist with a lot of scaling and scraping that aggravated the pain in her wrists. Dr. Bristow noted that Claimant felt her symptoms in the radial aspect of the wrist and thumb area. Dr. Bristow further noted that X-rays showed extremely advanced scaphotrapezoid arthritis, or STT arthritis.

7. Claimant was again evaluated by Dr. Bristow on August 11, 2009. Dr. Bristow noted the history that Claimant worked as a dental hygienist and used her hands for scraping and heavy pinching type work with instruments. On examination, Dr. Bristow noted that Claimant was having more soreness and crepitus at the basilar joint of the thumbs with the right being more symptomatic than the left. Dr. Bristow stated that he was not absolutely certain about the scaphotrapezial joint as related to Claimant's work but did note an increased incidence of basilar thumb arthritis in people who do firm steady pinching for long periods and that people who do fine firm work are at some increased risk for developing basilar thumb arthritis. Dr. Bristow suggested that Claimant may receive some temporary relief from cortisone injections.

8. Claimant typically works an 8 to 9 hour day for Employer with patients scheduled every 45 minutes on the days she works.

9. For typical patients, Claimant will perform an oral cancer examination, scaling, polishing, a periodontal examination, flossing and suction. These tasks require Claimant to use her left hand to manipulate a small mirror with pinching and grasping motion of the thumb to retract the tongue or cheek to permit examination of the mouth and teeth, to hold an instrument with paste for polishing or for suction. Claimant uses her right hand with pinching and grasping of the thumb to hold and manipulate instruments to scrape or scale the patients' teeth, polish the teeth, examine the periodontal pockets and to spray water to clean the mouth. Claimant uses her hand and thumbs bilaterally to floss the patients' teeth.

10. Claimant's primary problems are with the use of her thumbs, principally gripping with her thumbs. Claimant's thumb pain diminishes when she is away from work and returns with her return to work as a hygienist. Claimant's pain increases with more difficult patients and the activity of periodontal scaling is more stressful on her hands.

11. Claimant does not engage in any activities outside of work that require bilateral hand or thumb use. Claimant last played tennis approximately seven years ago with her daughter and had to stop this activity because of the pain in the thumbs. Claimant last played golf over 20 years ago. Claimant has not had any specific injuries to her thumbs or upper extremities. Claimant is right hand dominant.

12. Claimant was evaluated by Dr. Craig A. Davis on August 17, 2009 at the request of her counsel. Dr. Davis noted a recent history of fairly severely activity related pain on the radial side of both thumbs, right greater than left. Dr. Davis noted that Claimant worked as a dental hygienist using her right hand more than the left.

13. Dr. Davis diagnosed Claimant with scaphotrapezial trapezoid arthritis, bilateral wrists. Dr. Davis opined that degenerative arthritis of this type is a degenerative condition that is also generally felt to be due to use over time. Dr. Davis noted that the vast majority of Claimant's hand use is due to her work activities as a hygienist and opined that her work activities clearly aggravated the arthritis. Dr. Davis recommended treatment consisting of a steroid injection into the mid carpal joint.

14. At the request of Respondents Claimant was evaluated by Dr. Kavi Sachar, M.D. on May 6, 2009. Dr. Sachar diagnosed Claimant with bilateral thumb STT arthritis. Dr. Sachar opined that he did not feel this condition was work related because the findings were bilateral and symmetrical and because Dr. Sachar felt Claimant probably did not use her hands in a perfectly symmetrical fashion. Dr. Sachar also opined that STT arthritis is a very common condition and because the findings were symmetric, this pointed to a genetic cause rather than specific overuse activity. Dr. Sachar also considered that Claimant had only work 2 ½ days per week. Dr. Sachar opined that Claimant would be a reasonable candidate for bilateral STT fusions.

15. In a follow-up report dated October 6, 2009 Dr. Sachar stated that he was not aware of any medical studies that related STT arthritis to work as a dental hygienist and that typically there were no epidemiological studies disputing the relatedness of arthritis to work activities. Dr. Sachar, in his reports, does not address the question of whether Claimant's work activities as a dental hygienist intensified or aggravated her STT arthritis causing the need for medical treatment or causing a disability.

16. Claimant has proven by a preponderance of the evidence that she sustained a compensable occupational disease of bilateral STT arthritis from the conditions of her employment with Employer as a dental hygienist. The ALJ finds the opinions of Dr. Bristow and Dr. Davis to be more persuasive than the opinions of Dr. Sachar. The conditions of Claimant's work as a dental hygienist aggravated her STT arthritis causing the need for medical care as recommended by Dr. Davis.

17. Beginning December 18, 2008 Claimant reduced her work hours to just 2 days each week because of the pain in her thumbs and because the Employer felt it would be better for Claimant to only work two days per week.

18. The ALJ finds Claimant's testimony to be credible and persuasive.

CONCLUSIONS OF LAW

19. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must

be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

20. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

21. Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded. Section 8-41-301(1)(c), C.R.S.; *Faulkner v. Indus. Claim Appeals Office*, 12 P3d 844, 846 (Colo. App. 2000).

22. An occupational disease is “a disease which results directly from the employment or conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard which the worker would have been equally exposed outside of the employment.” Section 8-40-201(14), C.R.S.

23. A claimant seeking benefits for an occupational disease must first establish the existence of the disease and that it was directly and proximately caused by claimant’s employment or working conditions. *Wal-Mart Stores, Inc. v. Industrial Claims,* 989 P.2d 251, (Colo. App. 1999); *Cowin & Co. v. Medina*, 860 P. 2d 535 (Colo. App. 1992). In addition, a claimant must show that the identified disease resulted in disability. *Cowin, supra.*

24. A claimant is entitled to recovery for an occupational disease injury only if the hazards of employment cause, intensify or aggravate – to some degree – the disability for which compensation is sought. *Anderson v. Brinkhoff*, 839 P.2d 819, 824 (Colo. 1993). Where the disease for which a claimant is seeking compensation is produced solely by some extrinsic or independent cause, it is not compensable. *Id.* At 824. Further, where an occupational exposure is not a “necessary precondition” to the development of the disease, a claimant sustains an occupational disease only to the extent that the conditions of the employment contributed to the disability. *Id*. At 824; *Masdin v. Gardner-Denver-Cooper Indus.*, 689 P2d 714, 717 (Colo.App. 1984). The purpose of this rule “is to ensure that the disease results from the claimant’s occupational exposure to hazards of the disease and not hazards which the claimant is equally exposed to outside of employment.” *Saenz-Rico v. Yellow Freight System, Inc.*, W.C. No. 4-320-928

(January 20, 1998); *see also Stewart v. Dillon Co.*, W.C. No. 4-257-450 (November 20, 1996).

25. As found, Claimant has proven by a preponderance of the evidence that she sustained a compensable occupational disease of bilateral STT arthritis from the conditions of her employment with Employer as a dental hygienist. Dr. Sachar may well be correct that Claimant's employment did not cause this condition and that the condition is genetic in its origin. However, that is not the end of the analysis concerning whether Claimant has sustained a compensable occupational disease. Claimant is entitled to recovery for an occupational disease if the conditions of the employment intensify or aggravate to some degree the disability for which compensation is sought. Here, both Dr. Davis and Dr. Bristow's opinions support a finding that Claimant's employment aggravated or intensified her STT arthritis. Their opinions are supported by the credible testimony of Claimant that her symptoms are associated with, and increase with, her work as a hygienist. There is no persuasive evidence that Claimant's symptoms from STT arthritis causing the need for medical treatment and for Claimant to reduce her working hours came from some extrinsic or independent cause. Similarly, there is no persuasive evidence that Claimant was equally exposed outside of her employment to conditions requiring the type of pinching and grasping with her bilateral thumbs as is required in her work as a hygienist.

26. Claimant has proven by a preponderance of the evidence that her compensable occupational disease has caused the need for medical treatment. Dr. Bristow, Dr. Davis and Dr. Sachar have all opined that Claimant would benefit from treatment and their recommendations are essentially similar. Dr. Sachar did not mention injections but suggested surgery, a treatment avenue that was mentioned as a further possibility by both Dr. Bristow and Dr. Davis.

27. Claimant has proven by a preponderance of the evidence that her reduction in work hours beginning December 18, 2008 is causally related to the effects of her compensable occupational disease. The parties did not stipulate to an average weekly wage and this issue was not endorsed for determination by the ALJ at hearing. Although wage records were submitted, because the issue of computation of the average weekly wage was not submitted as an issue to be determined and was not stipulated to by the parties, the ALJ declines to address computation of average weekly wage. In the absence of a determination of average weekly wage, the ALJ is unable to enter a specific award of TPD benefits for Claimant as the ALJ is unable to calculate the specific amount of such benefits. This issue is left for the parties to resolve by agreement, if possible, or through subsequent hearing.

ORDER

It is therefore ordered that:

Claimant's claim for compensation and benefits for bilateral STT arthritis is GRANTED.

Claimant is entitled to the provision of medical benefits at the expense of Respondents that are reasonable, necessary and causally related to Claimant's compensable occupational disease and to be paid in accordance with the Medical Fee Schedule promulgated by the Division of Workers' Compensation.

No specific award to TPD benefits is made for the reasons set forth above and the ALJ makes no specific determination on an award of TPD benefits.

All matters not determined herein are reserved for future determination.

DATED: October 29, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-764-246

ISSUES

Whether Claimant's compensation benefits should be reduced by 50% for violation of a safety rule under Section 8-42-112(1)(b), C.R.S.

If Claimant's benefits are reduced under Section 8-42-112(1)(b), C.R.S. whether Respondents may recover a portion of the TTD benefits admitted and paid as an overpayment.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant was employed by Employer as a truck driver in the transportation department. Claimant's date of hire was January 31, 2008.

2. Employer adopted a set of "Ten Required Preferred Work Methods" for the purpose of promoting workplace safety and injury prevention. Work Method number 4 provides:

> "Observe ground and use 3-point stance when exiting tractor. Do not jump out of tractor or trailer."

3. Claimant on his date of hire with Employer signed off that he had read the Preferred Work Methods and understood that disciplinary action could be taken if he violated the Preferred Work Methods.

4. Claimant sustained an admitted injury to his left knee on June 11, 2008. Claimant underwent surgery on his left knee on July 14, 2009 for a tear of the lateral meniscus and anterior cruciate ligament performed by Dr. Failinger, M.D.

5. Claimant's injury occurred at approximately 1:30 PM on June 11, 2008 after Claimant had returned to Employer's facility from running his daily route. Claimant's responsibilities after completion of his route included performing a post-trip inspection on his truck, sweeping out the cargo box of the truck, cleaning the cab of the truck, removing any pallets or left-over produce from the cargo box and parking the truck in a designated parking area.

6. When Claimant returned from running his route on June 11, 2008 he began his assigned duty of sweeping out the cargo box of the truck. Claimant's truck did not have a broom to be used for sweeping the cargo box and Claimant went to a co-worker's truck parked next to him to borrow the broom from that truck.

7. Claimant climbed into the cargo box of his co-worker's truck and walked to the front of the truck to retrieve the broom from that truck. Claimant then walked to the back of the cargo box and placed the broom on the platform at the rear of the cargo box.

8. After placing the broom on the platform, Claimant then began to exit the cargo box. Claimant testified, and it is found, that he tried to use the required 3-point stance to exit the truck. As Claimant did so, he placed his right foot down to reach the step and slipped. Claimant then attempted to reach for the handle at the rear of the cargo box with his right hand and lost his balance. Claimant then turned and jumped to his left to avoid falling backwards and hitting his head. Claimant landed in a standing position on the floor on his left leg and then fell to the ground. The ALJ finds that Claimant's testimony and description of the circumstances and mechanism of his injury is credible and persuasive. There were no witnesses to Claimant's injury.

9. Claimant testified that he was aware of the requirement to use the 3-point stance, had this in mind when exiting the truck and did not intentionally violate that requirement at the time he sustained his injury on June 11, 2008. Claimant's testimony is credible, persuasive and is found as fact.

10. Employer completed an Employer's First Report of Injury for Claimant's June 11, 2008 injury. In the section of the Employer's First Report regarding whether the injury occurred because of a safety rule violation the box "not applicable" was checked.

11. The Employer's First Report of Injury was completed by Daher, Transportation Supervisor for Employer, and Claimant's direct supervisor. In the description of the accident Mr. Daher wrote "Stepping down off the rear box of truck". At some later time, the word "stepping" was lined out by an unknown person and the word "jumping" was substituted.

12. Mr. Daher also completed an Incident Report for Claimant's June 11, 2008 injury. Mr. Daher wrote that Claimant was stepping out of the back of truck at the time of the incident and that the description of how the incident happened was that Claimant had said that he jumped off the back of the truck.

13. S is the Vice-President of Operations for Employer. At the time Claimant's injury occurred Mr. S was upstairs in his office. Mr. S testified that it was his "impression" or "understanding" that Claimant had injured himself by jumping off the back of the truck. Mr. S reached his understanding of the circumstances of Claimant's injury through his conversation with other employees who had spoken with Claimant after the injury. Mr. S did not recall if Claimant had told him that he had jumped from the back of the truck.

14. The ALJ resolves the conflicts between the testimony of Mr. S, the entries on the Employer's First Report of Injury and the Incident Report and the Claimant's testimony regarding the circumstances and mechanism of Claimant's injury in favor of Claimant's testimony being the more credible and persuasive.

15. Respondents have failed to prove, by a preponderance of the evidence, that Claimant violated a safety rule requiring use of a 3-point stance when exiting the truck on June 11, 2008 when Claimant sustained his injury. There was also no persuasive evidence presented that any violation of a safety rule by Claimant was willful.

CONCLUSIONS OF LAW

Based on the preceding Findings of Fact, the ALJ makes the following Conclusions of Law:

16. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

17. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of

evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

18. Section 8-42-112(1), C.R.S. provides that the compensation provided for in articles 40 to 47 of this title shall be reduced fifty percent:

(a) Where the injury is caused by the willful failure of the employee to use safety devices provided by the employer;
(b) Where injury results from the employee's willful failure to obey any reasonable safety rule adopted by the employer for the safety of the employee;

19. The reduction in compensation for violation of a safety rule or failure to use a safety device is only applicable if the violation is willful. Respondents bear the burden of proof to establish that the Claimant's conduct was willful. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715 (Colo. App. 1995). Violation of a rule is not willful unless the claimant did the forbidden act with deliberate intention. *Bennett Properties Co. v. Industrial Commission*, 437 P.2d 548 (Colo. 1968); *Stockdale v. Industrial Commission*, 232 P. 669 (Colo. 1925); *Brown v. Great Peaks, Inc.*, W.C. No. 4-368-112 (Industrial Claim Appeals Office, July 29, 1999). Respondents satisfy the burden by showing that the employee knew of the rule yet intentionally performed the forbidden act; respondents need not show that the employee, having the rule in mind, determined to break it. *Stockdale v. Industrial Commission*, 76 Colo. 494, 232 P. 669 (1925). The Respondents need not produce direct evidence of the Claimant's state of mind. Willful conduct may be inferred from circumstantial evidence including the frequency of warnings, the obviousness of the danger, and the extent to which it may be said that the Claimant's actions were the result of deliberate conduct rather than carelessness or casual negligence. *Industrial Commission v. Golden Cycle Corp.,* 126 Colo. 68, 246 P.2d 902 (1952).

20. A violation which is the product of mere negligence, forgetfulness or inadvertence is not willful. *Johnson v. Denver Tramway Corp.*, 171 P.2d 410 (Colo. 1946). Conduct which might otherwise constitute a safety rule violation is not willful misconduct if the employee's actions were intended to facilitate accomplishment of a task or of the employer's business. *Grose v. Riviera Electric*, W.C. No. 4-418-465 (ICAO August 25, 2000). A violation of a safety rule will not be considered willful if the employee can provide some plausible purpose for the conduct. *City of Las Animas v. Maupin*, 804 P.2d 285 (Colo. App. 1990). The plausible purpose exception applies to circumstances where the Claimant's judgment ignoring the safety rule might have been faulty or the conduct rash. *Rhodes v. Empire Roofing,* W.C. No. 4-331-287 (January 25, 1999).

21. A safety rule or the requirement to use a safety device must be brought home to the employee and diligently enforced. *Pacific Employers Insurance Co. v. Kirkpatrick,* 111 Colo. 470, 143 P.2d 267 (1943). If the employer has knowledge of a violation but has failed to enforce the rule or requirement there is no reduction in the Claimant's compensation under Section 8-42-112. *Lori's Family Dining,* supra.

22. In addition to the requirement to prove that the failure to use a safety device or violation of a safety rule was willful, Respondents must also prove that the Claimant's injury was caused by such failure or resulted from such violation. Section 8-42-112(1)(a) and (b), C.R.S.

23. Respondents' argument for a reduction in Claimant's compensation due to violation of a safety rule is based upon their assertion that Claimant simply jumped off the back of his co-worker's truck without using the required 3-point stance thereby resulting in injury to Claimant's left knee. In support of this argument Respondents rely upon the testimony of Mr. S and his understanding of the circumstances and mechanism of Claimant's injury. However, Mr. S did not witness Claimant's injury nor did anyone else from Employer. Mr. S's understanding is based upon second hand information from other employee's who also did not witness the injury.

24. As found, Claimant's testimony concerning how the injury occurred is more credible and persuasive. Claimant was attempting to use the required 3-point stance in exiting the back of the cargo box of his co-worker's truck when he slipped and began to fall. While it is true that Claimant then jumped, he did so to avoid falling backward and landing on his head and also did so only after he had slipped on the step attempting to exit the truck with the required 3-point stance. The entries in the Employer's First Report and the Incident Report do not compel a different finding and conclusion. The lining out of the word "stepping" and replacing it with "jumping" in the First Report is not persuasive to show that Claimant simply jumped out of the truck without using or attempting to use the required 3-point stance. Similarly, the entries made in the Incident Report by Mr. Daher are not persuasive to show that Claimant simply jumped. The references in these reports to Claimant jumping are actually consistent with Claimant's testimony and description of the circumstances and mechanism of his injury. In this regard, the ALJ further concludes that Claimant had a plausible purpose for jumping in that Claimant was attempting to avoid a more serious injury to his head as he began to sense that he was falling from the truck.

25. As found, Respondents have failed to prove that Claimant violated a safety rule that resulted in his injury to his left knee on June 11, 2008. Respondents have failed to prove the necessary elements for reduction of Claimant's compensation benefits under Sections 8-42-112(1)(b), C.R.S. Accordingly, Respondents' request that Claimant's compensation benefits be reduced by 50% under Section 8-42-112(1)(b), C.R.S. must be denied. In light of this finding and conclusion, the ALJ need not address Respondents' request for recovery of an overpayment of TTD benefits to Claimant.

ORDER

It is therefore ordered that:

Respondents' request for a 50% reduction in Claimant's compensation benefits under Section 8-42-112(1)(b), C.R.S. is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: October 29, 2009

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-204-799

ISSUES

1. Whether Respondents have established by a preponderance of the evidence that they are entitled to reopen Claimant's workers' compensation claim because Claimant suffered a change in condition pursuant to §8-43-303(1), C.R.S.

2. Whether Respondents have demonstrated by a preponderance of the evidence that Claimant is no longer entitled to receive Permanent Total Disability (PTD) benefits because she is capable of earning wages.

3. Whether Claimant has presented substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of her industrial injury or prevent further deterioration of her condition pursuant to *Grover v. Industrial Comm'n.,* 759 P.2d 705 (Colo. 1988).

FINDINGS OF FACT

1. On February 28, 1992 Claimant suffered injuries to multiple levels of her back during the course and scope of her employment with Employer. While Claimant was driving a forklift she was forced to abruptly stop to avoid striking a fellow employee. Because of the incident she was thrown onto the floor of the forklift cab. Claimant immediately experienced lower back and leg pain.

2. Claimant subsequently underwent fusion surgeries in her lower back and thoracic spine. Doctors also implanted a neurostimulator and an intrathecal pump into Claimant's back.

3. On January 8, 1998 Claimant underwent a Functional Capacity Evaluation (FCE) to ascertain her employment capacity. The FCE resulted in work restrictions that included: (1) occasional sitting, standing, walking, squatting, climbing, bending, kneeling, reaching, crawling, pushing, and pulling; (2) lifting 12 inches to knuckle no more than 10 pounds; (3) lifting knuckle to shoulder no more than six pounds; (4) overhead lifting of no more than five pounds; and (5) no lifting from the floor to knuckle level.

4. On October 28, 1998 Respondents filed a Final Admission of Liability (FAL) in which they awarded Claimant's PTD benefits. The FAL also noted that Claimant had reached Maximum Medical Improvement (MMI) on June 30, 1997.

5. During the summer of 2004 physicians replaced the intrathecal pump in Claimant's back. Claimant was erroneously injected with subcutaneous morphine and local anesthetic Baclofen. She required life and ventilator support for two days. Claimant subsequently complained of cognitive deficits as a result of the incident.

6. Because of Claimant's cognitive deficits, she was referred to Thomas L. Bennett, PhD. for an evaluation. Dr. Bennett began treating Claimant on June 24, 2005. On August 23-24, 2005 Claimant underwent a neuropsychological assessment. Dr. Bennett determined that Claimant performed "very well" overall on the testing. Claimant specifically scored well on all tests of attention, concentration and problem solving. Claimant subsequently underwent approximately one year of neuropsychological treatment that ended on October 24, 2006. Dr. Bennett concluded that Claimant had gained many skills to cope with any cognitive limitations. His only concerns involved Claimant's sleeping difficulties and emotional liability.

7. Gregory Reichhardt M.D. conducted numerous independent medical evaluations of Claimant and testified through an evidentiary deposition in this matter. Claimant initially visited Dr. Reichhardt on October 10, 2005. Dr. Reichhardt explained that Claimant's lower back pain was related to her February 28, 1992 work incident. He also remarked that Claimant's "cognitive complaints may be in part related to the incident with the pain pump, although this is not at all clear." Dr. Reichhardt commented that Claimant's other conditions including thoracic pain, neck pain, headaches, bowel and bladder incontinence, knee pain and abdominal pain were unrelated to her work incident. He testified that Claimant demonstrated significant loss of range of motion in both her cervical and lumbar areas. Dr. Reichhardt also stated that Claimant was unsteady and typically required the assistance of a cane during the evaluation.

8. At the hearing in this matter Respondents introduced surveillance video of Claimant that was taken on December 28, 2005, January 6, 2006, January 7, 2006 and September 20, 2006. Although the video at hearing lasted approximately 50 minutes, the total surveillance video lasted over four hours.

9. On April 7, 2006 Dr. Reichhardt reviewed all of the surveillance video. The video documented Claimant performing various activities that included lifting, bending, kneeling, and squatting. She performed the activities in a fluid manner without hesitation. Dr. Reichhardt also made the following observations:

> In my examination of [Claimant] on October 10, 2005, she walked with a cane. She had give-way weakness. On the surveillance video, she is generally walking without a cane. It is interesting to note that the only occasion she is seen walking with a cane is when she is in town in a public environment. When she is at home in a more private environment, she does not utilize a cane. It is noted that when she is at home not using the cane, she does not demonstrate any evidence of a limitation in her gait. She does not demonstrate any evidence of any need for use of a cane. It is noted she is able to walk without limitations and even seen running on a number of occasions without any obvious pain or limitation. During her ac-

> tivities, there is no evidence of lower extremity weakness that she demonstrated on her 10/10/05 exam, confirming that the weakness she demonstrated is non-physiologic in nature, rather than true neurogenic weakness. One would not anticipate that an individual experiencing the pain levels that she reportedly experiences would perform the activities that she is seen performing in this video. She demonstrates significant bending activities. She carries an oversized load of hay. I would anticipate that if she was prone to experience the pain levels that she reports, she would break this load into multiple smaller loads. One would not anticipate that [Claimant], based on her presentation in the office, would run in the fashion that she does in the video.

10. Dr. Reichhardt summarized that Claimant was capable of functioning in at least a light work category. He explained that Claimant could occasionally lift up to 20 pounds and frequently lift up to 10 pounds. He also recommended that Claimant could bend, twist and engage in overhead work on an occasional basis.

11. On January 29, 2007 Claimant underwent a second FCE. Claimant described her abilities as follows: sitting for five minutes, standing for 20 minutes, walking for 30 minutes, driving for 60 minutes and lifting no more than five pounds. During the FCE Claimant demonstrated decreased balance with a severe staggering gait. She required a cane for carrying, stair climbing, and walking. Claimant was only able to demonstrate lifting of no more than five pounds. When she attempted to lift from the floor she required a golfer's lift with a shelf for support. Claimant demonstrated significant restrictions in her lumbar and cervical range of motion. She also exhibited significant limitations in her shoulder range of motion.

12. Dr. Reichhardt reviewed the January 29, 2007 FCE. In a report dated July 13, 2007 Dr. Reichhardt did not believe that the results of the FCE accurately documented the types of restrictions appropriate for Claimant. First, Dr. Reichhardt commented that there was no medical evidence suggesting that Claimant's functional ability would have declined so dramatically between the time of her surveillance video and her FCE. He also remarked that during the FCE Claimant demonstrated a severe staggering gait but in the surveillance video Claimant walked on unpaved surfaces without any difficulty and without using a cane. Dr. Reichhardt noted that when Claimant reached for objects on the floor she used a golfer's lift with a shelf for support. However, in the surveillance video Claimant bent over and picked many objects up from the floor without any need for support. The FCE also noted that Claimant needed several rests between activities and terminated the testing due to burning in her neck. In contrast, the surveillance video demonstrated that Claimant could perform a number of more challenging activities and did not need to rest on a frequent basis. Dr. Reichhardt also explained that Claimant's lumbar and cervical range of motion during the FCE was significantly diminished compared to her actions in the surveillance video. Finally, Claimant demonstrated severe range of motion restrictions in flexion and abduction in both shoulders during the FCE. However, Dr. Reichhardt noted that there was no medical reason as to why Claimant would have limited range of motion in her shoulders.

13. On April 3, 2007 Claimant was involved in a motor vehicle accident. While Claimant was stopped she was rear-ended by another vehicle that was traveling at approximately 50 miles per hour. The parties in the present matter subsequently executed a stipulation providing that the April 3, 2007 motor vehicle accident was unrelated to Claimant's Workers' Compensation claim.

14. During Spring and Summer 2007 Claimant's spinal cord stimulator and pain pump were removed because of infections. Dr. Reichhardt opined that the removal of the devices was directly related to the April 3, 2007 motor vehicle accident. He explained that because of the high-speed nature of the accident Claimant's implants were disrupted and required removal.

15. On June 17, 2008 Claimant underwent cervical spine surgery. She received an artificial disc replacement.

16. In October 2008 Claimant was involved in another motor vehicle accident. She testified that the accident exacerbated her neck, arm, lower back, hip and leg symptoms. Claimant also noted that the accident caused her to suffer bowel dysfunction. Nevertheless, when Claimant visited Dr. Reichhardt for an examination on January 19, 2009 she did not mention any increased symptoms or bowel dysfunction as a result of an October 2008 motor vehicle accident.

17. On April 21, 2009 Vocational Consultant Katie Montoya evaluated Claimant. Ms. Montoya prepared a report and testified through an evidentiary deposition in this matter. Relying on the work restrictions supplied by Dr. Reichhardt, Ms. Montoya concluded that Claimant was capable of earning wages in some capacity near her residence in the Cheyenne, Wyoming area. She explained that because of the length of time that Claimant had been out of work her options were limited to unskilled or semi-skilled employment. Nevertheless, Ms. Montoya identified several job titles that Claimant would be able to perform in the unskilled or semi-skilled area, including assembly work, sales work, and counter attendant. In her deposition, Ms. Montoya also added jobs including service attendant, cashier, and order clerk that Claimant was capable of performing. She commented that people could learn the preceding jobs fairly quickly. Ms. Montoya also remarked that the jobs were readily available in the Cheyenne, Wyoming labor market.

18. On July 13, 2009 Authorized Treating Physician (ATP) Kenneth A. Pettine, M.D, imposed the following restrictions on Claimant: occasional lifting of 10 pounds, frequent lifting of five pounds, no bending or twisting at the waist, no overhead work, standing or sitting for no more than 30 minutes at a time and no repetitive use of the hands.

19. Dr. Reichhardt reviewed the restrictions imposed by Dr. Pettine. He initially commented that Dr. Pettine's restrictions did not differentiate between the restrictions related to the 1992 work-related injury and those pertaining to the April 2007 motor vehicle accident. Dr. Reichhardt also testified that any deterioration in Claimant's physical condition was not a natural progression of the 1992 work-related injury but was instead

related to the April 2007 motor vehicle accident. He explained that Claimant's treatment was fairly stable in October 2006 and that she was doing well with pain management. Moreover, the surveillance video demonstrated that Claimant was functioning at a high level. There was thus no reason to believe that Claimant's condition was on a "downward trajectory." However, Claimant's condition suddenly worsened after her April 3, 2007 motor vehicle accident. The accident caused her to require neck surgery and disrupted her two implantable pain systems.

20. Claimant testified at the hearing that she visits her message therapist and physical therapist in the Loveland, Colorado area on a weekly basis. Claimant also has a health club membership in the Loveland area. Claimant's mileage reimbursement records reflect that she has traveled from her residence in Cheyenne to Loveland several times each week and totaled over 4,000 miles each month between 2005 and 2009. Claimant explained that she seeks to continue physical therapy and massage therapy in the Loveland area because her providers are familiar with her special condition and she trusts them.

21. In his January 19, 2009 report Dr. Reichhardt addressed Claimant's continuing need for physical therapy and massage therapy. He explained:

> [Claimant] reports that she has been receiving weekly physical therapy and massage therapy visits. There is no justification in the records that I reviewed for weekly massage therapy or physical therapy treatments. She receives short-term benefits from the massage therapy. She reports that she needs it in order to stay functional. I would question this based on the issues on the surveillance video. Although she is not sure that the individual is her at all times, she did indicate on some sections that it is her and she did indicate on other sections that she would have done similar activities. I would not expect an individual who participates in these types of activities to require massage therapy on a weekly basis just to stay functional with basic activities. I would not recommend more than 8 physical therapy visits per year and 8 massage therapy visits per year to manage flare-ups.

22. Dr. Reichhardt provided further justifications as to why he would limit Claimant to eight physical therapy visits per year and eight massage therapy visits each year. He commented that, according to the medical treatment guidelines, passive treatment modalities should not be emphasized to alleviate chronic pain. Instead, the emphasis for chronic pain patients should be independence and self-management of symptoms. Continued use of passive modalities without clear goals is not advised. Physical therapy appointments should be oriented toward assisting Claimant with her independent exercise program and to resolve any flare-ups. Massage therapy also should be used only for management of flare-ups.

23. Dr. Reichhardt also explained that Claimant's massage and physical therapy sessions should be conducted in the Cheyenne area. He commented that it is not medically contraindicated to transfer Claimant's massage and physical therapy visits to the

Cheyenne area. Dr. Reichhardt explained that, although Claimant has a complex medical history, her new providers can easily be apprised of her conditions. He also remarked that Claimant has suffered several recent motor vehicle accidents and has reported that she has difficulty controlling her legs at times. Dr. Reichhardt thus stated that Claimant would benefit from less travel and treatment closer to her home.

24. In considering Claimant's health club membership in Loveland, Dr. Reichhardt explained that a health club program would more properly be considered under "general wellness and fitness" rather than work-related. He commented that Claimant did not need to travel to Loveland to find an appropriate health club and could simply attend a health club on her own in Cheyenne.

25. ATP David L. Reinhard, M.D. reviewed Dr. Reichhardt's January 19, 2009 report. In a March 9, 2009 letter Dr. Reinhard explained that he agreed with Dr. Reichhardt's recommendations. He then prescribed eight physical therapy and eight massage therapy sessions for Claimant at Avenues Therapy Clinic in Cheyenne. Dr. Reinhard noted in his prescription that Claimant had undergone lower and mid-back fusions, experienced cervical problems and used a pain pump.

26. Respondents have demonstrated that it is more probably true than not that Claimant's condition has changed since she was deemed permanently and totally disabled in 1998. Dr. Reichhardt credibly concluded that Claimant's physical condition has significantly improved since 1993. He noted that Claimant's activities in the surveillance videos, including walking without a cane and carrying bales of hay, exceeded the abilities that she demonstrated upon examination. Dr. Reichhardt specifically noted that Claimant used a cane in a public environment but did not utilize a cane while performing activities on her property. Her activities in the video did not reveal any limitations in her gait or need for a cane. Dr. Reichhardt thus explained that there was no evidence in the video of the lower extremity weakness that Claimant had demonstrated in her October 10, 2005 examination. Based on his examinations and review of the surveillance videos Dr. Reichhardt persuasively concluded that Claimant was capable of functioning in at least a light work category, with lifting 20 pounds on occasion and 10 pounds frequently. He also determined that Claimant could bend, twist and engage in overhead work on an occasional basis.

27. Claimant was involved in a motor vehicle accident on April 3, 2007. Dr. Reichhardt credibly testified that any deterioration in Claimant's physical condition was not the natural progression of the 1992 work-related injury but instead pertained to the April 2007 motor vehicle accident. Although Dr. Pettine imposed significant work restrictions on Claimant in July 13, 2009 Dr. Reichhardt noted that the restrictions did not differentiate between any limitations related to the 1992 work-related injury and those related to the April 2007 motor vehicle accident. More importantly, there was no evidence in the medical records that Claimant's condition was on a "downward trajectory" prior to the accident. However, Claimant's condition suddenly worsened after her April 3, 2007 motor vehicle accident. Therefore, based on the credible testimony of Dr. Reichhardt, any worsening of Claimant's condition is related to the intervening event of the April

2007 motor vehicle accident. Without regard to the accident Claimant's physical condition, as documented in the surveillance videos, has significantly improved since she was deemed permanently and totally disabled.

28. Relying on the work restrictions imposed by Dr. Reichhardt, Vocational Consultant Ms. Montoya persuasively concluded that Claimant was capable of earning wages in some capacity in the Cheyenne, Wyoming area. She identified several unskilled or semi-skilled job titles that Claimant could perform including assembly work, sales work, and counter attendant. In her deposition, Ms. Montoya also added the job titles of service attendant, cashier, and order clerk that Claimant was capable of performing. She commented that these jobs are the kinds that people could learn fairly quickly. Ms. Montoya also remarked that these jobs were readily available in the Cheyenne, Wyoming labor market. Based on the unrebutted testimony of Ms. Montoya, Claimant is capable of earning wages in some capacity in the Cheyenne labor market.

29. The record includes substantial evidence to support a determination that future medical treatment in the form of eight physical therapy and eight massage therapy sessions **in Cheyenne** will be reasonably necessary to relieve the effects of Claimant's industrial injury or prevent further deterioration of her condition. However, there is insufficient evidence to support a determination that Claimant is entitled to a health club membership in Loveland. Dr. Reichhardt persuasively explained that Claimant should be limited to eight physical therapy and eight massage therapy sessions each year. He reasoned that, according to the medical treatment guidelines, passive treatment modalities should not be emphasized for chronic pain. Instead, the emphasis for chronic pain patients should be independence and self-management of symptoms. Physical therapy appointments should be oriented toward assisting Claimant with her independent exercise program and to resolve any flare-ups. Massage therapy should also only be used for management of flare-ups. Dr. Reichhardt commented that it is not medically contraindicated to transfer Claimant's massage and physical therapy visits to the Cheyenne area. He expressed concerns about Claimant's ability to safely travel from Cheyenne to Loveland. Finally, Dr. Reichhardt credibly explained that a health club program would more properly be considered "general wellness and fitness" rather than work-related. He commented that Claimant did not need to travel to Loveland to find an appropriate health club and could simply attend a health club on her own in Cheyenne. ATP Dr. Reinhard agreed with Dr. Reichhardt's recommendations and prescribed eight physical therapy and eight massage therapy sessions for Claimant at Avenues Therapy Clinic in Cheyenne.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of

the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Reopening

4. Section 8-43-303(1), C.R.S. provides that a worker's compensation award may be reopened based on a change in condition. The moving party shoulders the burden of proving a claimant's condition has changed. *See Osborne v. Industrial Commission*, 725 P.2d 63, 65 (Colo. App. 1986). A change in condition refers either to a change in the condition of the original compensable injury or to a change in the claimant's physical or mental condition that is causally connected to the original injury. *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082, 1084 (Colo. App. 2002).

5. As found, Respondents have demonstrated by a preponderance of the evidence that Claimant's condition has changed since she was deemed permanently and totally disabled in 1998. Dr. Reichhardt credibly concluded that Claimant's physical condition has significantly improved since 1993. He noted that Claimant's activities in the surveillance videos, including walking without a cane and carrying bales of hay, exceeded the abilities that she demonstrated upon examination. Dr. Reichhardt specifically noted that Claimant used a cane in a public environment but did not utilize a cane while performing activities on her property. Her activities in the video did not reveal any limitations in her gait or need for a cane. Dr. Reichhardt thus explained that there was no evidence in the video of the lower extremity weakness that Claimant had demonstrated in her October 10, 2005 examination. Based on his examinations and review of the surveillance videos Dr. Reichhardt persuasively concluded that Claimant was capable of functioning in at least a light work category, with lifting 20 pounds on occasion and 10 pounds frequently. He also determined that Claimant could bend, twist and engage in overhead work on an occasional basis.

6. As found, Claimant was involved in a motor vehicle accident on April 3, 2007. Dr. Reichhardt credibly testified that any deterioration in Claimant's physical con-

dition was not the natural progression of the 1992 work-related injury but instead pertained to the April 2007 motor vehicle accident. Although Dr. Pettine imposed significant work restrictions on Claimant in July 13, 2009 Dr. Reichhardt noted that the restrictions did not differentiate between any limitations related to the 1992 work-related injury and those related to the April 2007 motor vehicle accident. More importantly, there was no evidence in the medical records that Claimant's condition was on a "downward trajectory" prior to the accident. However, Claimant's condition suddenly worsened after her April 3, 2007 motor vehicle accident. Therefore, based on the credible testimony of Dr. Reichhardt, any worsening of Claimant's condition is related to the intervening event of the April 2007 motor vehicle accident. Without regard to the accident Claimant's physical condition, as documented in the surveillance videos, has significantly improved since she was deemed permanently and totally disabled.

PTD Benefits

7. Respondents assert that Claimant is no longer entitled to receive PTD benefits because she is capable of earning wages. Under §8-40-201(16.5)(a), C.R.S. PTD means "the employee is unable to earn any wages in the same or other employment." A claimant thus cannot obtain PTD benefits if she is capable of earning wages in any amount. *Weld County School Dist. RE-12 v. Bymer*, 955 P.2d 550, 556 (Colo. 1998).

8. A claimant's industrial injuries must constitute a "significant causative factor" in order to establish a claim for PTD. *In Re Olinger,* W.C. No. 4-002-881 (ICAP, Mar. 31, 2005). A "significant causative factor" requires a "direct causal relationship" between the industrial injuries and a PTD claim. *In Re of Dickerson,* W.C. No. 4-323-980 (ICAP, July 24, 2006); *see Seifried v. Industrial Comm'n,* 736 P.2d 1262, 1263 (Colo. App. 1986). The preceding test requires the ALJ to ascertain the "residual impairment caused by the industrial injury" and whether the impairment was sufficient to result in PTD without regard to subsequent intervening events. *In Re of Dickerson,* W.C. No. 4-323-980 (ICAP, July 24, 2006). Resolution of the causation issue is a factual determination for the ALJ. *Id.*

9. In ascertaining whether a claimant is able to earn any wages, the ALJ may consider various "human factors," including a claimant's physical condition, mental ability, age, employment history, education, and availability of work that the claimant could perform. *Bymer*, 955 P.2d at 556; *Holly Nursing v. ICAO,* 992 P.2d 701, 703 (Colo. App. 1999). The critical test, which must be conducted on a case-by-case basis, is whether employment exists that is reasonably available to the claimant under her particular circumstances. *Bymer,* 955 P.2d at 557. Ultimately, the determination of whether a Claimant suffers from a permanent and total disability is an issue of fact for resolution by the ALJ. *In Re Selvage,* W.C. No. 4-486-812 (ICAP, Oct. 9, 2007). Accordingly, in seeking to reopen a PTD award based on a change in condition, Respondents must present evidence that employment is reasonably available to the claimant and she is capable of earning wages in some amount. *See In Re Epp,* W.C. No. 3-999-840 (ICAP, Feb.12, 2002).

10. As found, relying on the work restrictions imposed by Dr. Reichhardt, Vocational Consultant Ms. Montoya persuasively concluded that Claimant was capable of earning wages in some capacity in the Cheyenne, Wyoming area. She identified several unskilled or semi-skilled job titles that Claimant could perform including assembly work, sales work, and counter attendant. In her deposition, Ms. Montoya also added the job titles of service attendant, cashier, and order clerk that Claimant was capable of performing. She commented that these jobs are the kinds that people could learn fairly quickly. Ms. Montoya also remarked that these jobs were readily available in the Cheyenne, Wyoming labor market. Based on the unrebutted testimony of Ms. Montoya, Claimant is capable of earning wages in some capacity in the Cheyenne labor market.

Medical Maintenance Benefits

11. To prove entitlement to medical maintenance benefits, a claimant must present substantial evidence to support a determination that future medical treatment will be reasonably necessary to relieve the effects of the industrial injury or prevent further deterioration of his condition. *Grover v. Industrial Comm'n.,* 759 P.2d 705, 710-13 (Colo. 1988); *Stollmeyer v. Industrial Claim Appeals Office,* 916 P.2d 609, 611 (Colo. App. 1995). Once a claimant establishes the probable need for future medical treatment he "is entitled to a general award of future medical benefits, subject to the employer's right to contest compensability, reasonableness, or necessity." *Hanna v. Print Expediters, Inc.*, 77 P.3d 863, 866 (Colo. App. 2003); *see Karathanasis v. Chilis Grill & Bar,* W.C. No. 4-461-989 (ICAP, Aug. 8, 2003). Whether a claimant has presented substantial evidence justifying an award of *Grover* medical benefits is one of fact for determination by the Judge. *Holly Nursing Care Center v. Industrial Claim Appeals Office,* 919 P.2d 701, 704 (Colo. App. 1999).

12. As found, the record includes substantial evidence to support a determination that future medical treatment in the form of eight physical therapy and eight massage therapy sessions in Cheyenne will be reasonably necessary to relieve the effects of Claimant's industrial injury or prevent further deterioration of her condition. However, there is insufficient evidence to support a determination that Claimant is entitled to a health club membership in Loveland. Dr. Reichhardt persuasively explained that Claimant should be limited to eight physical therapy and eight massage therapy sessions each year. He reasoned that, according to the medical treatment guidelines, passive treatment modalities should not be emphasized for chronic pain. Instead, the emphasis for chronic pain patients should be independence and self-management of symptoms. Physical therapy appointments should be oriented toward assisting Claimant with her independent exercise program and to resolve any flare-ups. Massage therapy should also only be used for management of flare-ups. Dr. Reichhardt commented that it is not medically contraindicated to transfer Claimant's massage and physical therapy visits to the Cheyenne area. He expressed concerns about Claimant's ability to safely travel from Cheyenne to Loveland. Finally, Dr. Reichhardt credibly explained that a health club program would more properly be considered "general wellness and fitness" rather than work-related. He commented that Claimant did not need to travel to Loveland to find an appropriate health club and could simply attend a health club on her own in Cheyenne.

ATP Dr. Reinhard agreed with Dr. Reichhardt's recommendations and prescribed eight physical therapy and eight massage therapy sessions for Claimant at Avenues Therapy Clinic in Cheyenne.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Respondents' request to reopen the matter is granted.

2. Respondents' request to terminate Claimant's PTD benefits is granted.

3. Claimant is entitled to medical maintenance benefits in the form of eight physical therapy and eight massage therapy sessions per year in Cheyenne, Wyoming. Claimant is not entitled to a health club membership.

4. All issues not resolved in this Order are reserved for future determination.

DATED: October 30, 2009.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-649-193

ISSUES

The issue raised for consideration at hearing is whether Claimant's condition has worsened since being placed a maximum medical improvement (MMI) and whether his petition to reopen the claim should be granted.

FINDINGS OF FACT

Having considered the evidence presented at hearing, the following Findings of Fact are entered.

1. Claimant is a 73-year-old man who sustained a work-related injury on April 11, 2005, when he was performing his job as a maintenance man at the Employer. Claimant slipped on some ice and twisted his back. The claim was accepted and Claimant underwent treatment at Concentra Medical Centers.

2. On November 10, 2005, Claimant was placed at maximum medical improvement (MMI) by Albert Hattem, M.D. with a 19% whole person impairment rating and permanent restrictions.

3. Claimant filed an Application for Division independent medical evaluation (DIME) on April 4, 2007, stating that the specific body parts that he wanted to be evaluated were low back pain, psychological, and all other issues related to the industrial injury.

4. John Bissell, M.D. performed the DIME on June 25, 2007. Dr. Bissell evaluated Claimant's psychological issues and low back pain. Dr. Bissell agreed with the November 10, 2005, date of maximum medical improvement, and gave Claimant a 23% whole person rating. Dr. Bissell opined that Claimant did not receive any rating for a psychological condition.

5. Subsequently, Respondents filed an Application for Hearing on July 19, 2007, endorsing the issue of permanent partial disability benefits. Claimant did not file a Response to the Application for Hearing. A hearing was held on November 7, 2007 in which ALJ Walsh determined that Dr. Bissell's whole person impairment rating of 23% was correct.

6. Respondents filed a Final Admission of Liability on December 20, 2007, consistent with the Findings of Fact, Conclusions of Law, and Order. Thereafter, Claimant filed an Application for Hearing on January 18, 2008, on the issue of permanent total disability benefits.

7. On February 15, 2008, Respondents filed a Motion to Strike Claimant's Application for Hearing alleging that the issue of permanent total disability benefits was ripe at the time Respondents filed their Application for Hearing on July 19, 2007. Respondents argued in their motion that when a Claimant fails to endorse the issue of permanent total disability within thirty (30) days of a final admission of liability, or in response to Respondents' application for hearing as required by Section 8-43-203(2)(b)(II), C.R.S. those issues are closed and cannot be litigated. *Olivas-Soto v. Indus. Claims Appeals Office* 143 P.3d 1178 (Colo. App. 2006).

8. On February 29, 2008, an Order was granted striking Claimant's Application for Hearing. Approximately 10 months after this Order was granted, Claimant filed a Petition to Reopen based on a change of condition.

9. Claimant filed an Application for Hearing on June 8, 2009, alleging a petition to reopen based on a change of condition, medical benefits, and temporary disability benefits. Respondents filed a Response to the Application for Hearing on July 7, 2009, endorsing defenses such as claim preclusion, issue preclusion, waiver, Claimant did not suffer worsening of condition, and that Claimant's case remains closed. This Application and Response was the subject of the September 30, 2009, hearing.

10. Claimant first treated with Daniel Gibertini, M.D. at Concentra Medical Centers on April 12, 2005. Claimant was is a fair amount of discomfort secondary to his back pain. Claimant reported that x-rays were negative. Dr. Gibertini diagnosed Claim-

ant with a lumbar strain. Dr. Gibertini recommended physical therapy and medications to control Claimant's pain.

11. Claimant underwent a lumbar MRI of the lumbar spine on June 8, 2005. The MRI showed chronic appearing anterior wedging of the L4, L2, and T12 vertebral bodies and mild to moderate degenerative disc disease of the lumbar spine with relative sparing of the L4-L5 disc.

12. On September 28, 2005, Claimant was reexamined by Daniel Baer, D. O. Dr. Baer noted that Claimant underwent physical therapy, chiropractic care, epidural steroid injections, facet injections, and a surgical consultation with James Bee, M.D. Dr. Bee determined that Claimant was not a surgical candidate. Claimant stated that none of those treatments were beneficial and that he still had back pain. Dr. Baer determined that Claimant was at MMI.

13. Dr. Hattem evaluated Claimant on November 11, 2005. Claimant complained of persistent low back pain at 7-8/10. Claimant stated that he was currently taking Tramadol and Skelaxin for pain. Dr. Hattem opined that because Claimant failed to respond to all conservative measures consisting of physical therapy, chiropractic treatment, facet injection, epidural steroid injections, and that Claimant was not a surgical candidate, Claimant was at maximum medical improvement. Dr. Hattem opined that additional conservative measures were not likely to be beneficial. Dr. Hattem gave Claimant a 19% whole person impairment rating, permanent restrictions, and recommended medical maintenance care.

14. Claimant did not return for an appointment with Concentra until January 18, 2007, almost 14 months after being placed at maximum medical improvement. Claimant complained of persistent even worsening low back pain during the last 6 months and that he could not walk more than 50 feet. Claimant also stated that he never settled his case. Claimant rated his low back pain as 7-8/10. Dr. Hattem recommended an MRI of Claimant's lumbar spine.

15. On February 7, 2007, Claimant underwent another lumbar spine MRI. This MRI determined that the overall appearance of the spine had not changed since the prior study on June 8, 2005.

16. On April 26, 2007, Claimant was reevaluated by Dr. Hattem. Claimant continued to complain of persistent unchanged low back pain. Dr. Hattem advised Claimant that because the lumbar MRI was unchanged there was no specific indication for any specific interventions.

17. Claimant underwent the Division IME with Dr. Bissell on June 25, 2007. Claimant stated that he can sit for several hours but only stand for 15 minutes and walk no more than 75 yards. Claimant reported his pain 7/10 and 9+/10 with activity. Additionally, Claimant reported that he felt that the impairment rating he received from Dr. Hattem was not reflective of the amount of disability he suffered. Additionally, Claimant

stated that before the injury he was able to do physical activity but now he cannot do much of anything. Dr. Bissell gave Claimant a 23% whole person impairment rating for his low back condition. However, Dr. Bissell did not rate the Claimant for any psychological condition. Additionally, Dr. Bissell determined that Claimant's date of maximum medical improvement was November 10, 2005.

18. Claimant returned for an evaluation with Dr. Hattem on January 10, 2008, almost eight and half months since his previous examination. Claimant stated that his condition remained unchanged since April 2007. Additionally, Claimant stated that he had not yet settled his claim. Dr. Hattem recommended medications of Tramadol and Amitriptyline.

19. Claimant underwent a Claimant's independent medical evaluation with David Richman, M.D. on December 12, 2008. Claimant stated that his pain level was between a 5-8/10, and that he cannot do anything but sit in his recliner all day. Additionally, Claimant stated that he was getting medications through Concentra, but that he did not actually see any treatment provider at Concentra during the last two years. Dr. Richman diagnosed Claimant with some depression and that a new MRI be performed to determine whether or not Claimant was no longer at maximum medical improvement for his lumbar injury.

20. On February 19, 2009, Dr. Hattem reevaluated Claimant, almost 13 months since the previous evaluation. Claimant rated his pain at a 7/10. Dr. Hattem reviewed Dr. Richman's recommendations and thought that the recommendations were reasonable. However, Dr. Hattem disagreed with Dr. Richman and opined that Claimant remained at maximum medical improvement. Dr. Hattem opined that Dr. Richman's recommendations should be part of a maintenance plan because the recommendations would not result in significant functional gains for Claimant.

21. Claimant then underwent a third MRI of the lumbar spine on March 2, 2009. The MRI's impression was multilevel degenerative disc disease and endplate spondylosis without appreciable interval change as compared to prior study. Again, this March 2, 2009, MRI did not show any change from either the June 8, 2005, or the February 7, 2007, MRI studies.

22. Claimant returned on March 12, 2009 for an evaluation with Dr. Hattem. Claimant rated his pain at 8/10. Additionally, Dr. Hattem noted that Claimant was not in any acute distress. Dr. Hattem noted that Claimant's MRI remained unchanged from the previous MRI studies.

23. On April 13, 2009, Claimant was evaluated by John Sacha, M.D. On examination, Dr. Sacha noted that Claimant had pain behaviors and that Waddell's testing was 4/5 positive. Dr. Sacha recommended medial branch blocks. Subsequently, Dr. Sacha opined on May 5, 2009, that the medial branch blocks would be considered medical maintenance care and that Claimant remained at MMI.

24. Claimant testified that he has developed depression due to his chronic pain. However, on cross-examination, Claimant testified that he was frustrated that his case had not settled and was still in litigation four and half years after he sustained his injury. Claimant testified that he wants his case to be over.

25. Claimant stated that he was on Tramadol and Amtriptyline, but that Dr. Sacha took him off these medications because of elevated liver functions. Claimant also testified that before he was taken off all of his medications he could walk around his apartment complex. Claimant then testified that Dr. Sacha put him back on Avinza, a pain medication.

26. Moreover, Claimant testified that he felt that the physicians have not done enough to relieve his pain. On cross examination, Claimant testified that his pain complaints have not subsided, but he agreed that he still had the same pain complaints he did as of November 10, 2005, the date he was placed at maximum medical improvement. Claimant testified that his pain complaints remained 7-8/10, which was the same pain complaint he had at the date of maximum medical improvement.

27. Dr. Hattem testified as a board-certified occupational medicine physician. Dr. Hattem testified that he evaluated Claimant on January 18, 2007, April 26, 2007, January 10, 2008, February 19, 2009, and March 12, 2009. Dr. Hattem also testified that he reexamined Claimant on January 10, 2008, and that examination remained unchanged from the previous examinations.

28. Additionally, Dr. Hattem testified that at Claimant's February 19, 2009, examination, Claimant complained of worsening low back pain. However, Claimant rated his pain at 7/10, which is the same rating that Claimant ordinarily gave. Additionally, Dr. Hattem testified that he reviewed Dr. Richman's report that stated Claimant complained of pain between 5-8/10, which corresponded to what Claimant has complained of since treatment.

29. Subsequently, Dr. Hattem testified that Dr. Richman opined that Claimant was no longer at maximum medical improvement. However, Dr. Hattem did not agree with that opinion. Dr. Hattem did testify that he sent Claimant for a repeat MRI pursuant to Dr. Richman's recommendations, but the repeat MRI showed no objective changes from the two prior MRI studies. Additionally, Dr. Hattem testified that at the March 12, 2009 evaluation, Claimant's pain complaints remained unchanged from his previous examinations.

30. Furthermore, Dr. Hattem testified that the recommendations made by Dr. Richman such as the MRI, treatment for depression, and medial branch blocks should be considered medical maintenance. Dr. Hattem testified that the basis for his opinion was that the recommendations should be considered medical maintenance because it was not going to impact Claimant's functional status. These recommendations were mainly for pain control. Additionally, Dr. Hattem testified that his opinion that these treatments were for maintenance care remained unchanged.

31. Dr. Hattem further testified that Dr. Sacha evaluated Claimant on April 13, 2009, and that Dr. Sacha determined Claimant to have positive 4/5 Waddell's signs. Dr. Hattem credibly testified that Waddell's signs are an indication that complaints of pain may not be related to an actual physical problem but due to psychosocial issues or malingering. Furthermore, Dr. Hattem agreed with Dr. Sacha that if Claimant underwent medial branch blocks that should be considered maintenance care.

32. Dr. Hattem credibly and persuasively testified that frustration can lead to depression, and that any treatment for Claimant's alleged depression should be considered medical maintenance treatment. Furthermore, Dr. Hattem testified to a reasonable degree of medical probability that Claimant did not sustain a worsening of condition

33. On cross examination, Dr. Hattem testified that he was unaware of why Claimant had elevated liver function tests because the narcotic medications Claimant was taking, Tramadol and Avinza, could not cause elevated liver function tests. Dr. Hattem testified that Claimant could have some sort of liver condition affecting Claimant's liver enzymes.

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the following Conclusions of Law are entered.

1. Claimant contends that he is entitled to reopen his claim because his condition has worsened. Respondents maintain that Claimant is not entitled to an order reopening his claim because Claimant's condition has not worsened since the date that he was placed at MMI. Based on the totality of the evidence presented at hearing, with reliance on the credible testimony and medical records of Dr. Hattem, it is found and concluded that Claimant has not demonstrated a worsened condition since the being placed at MMI on November 10, 2005.

2. In order to reopen a claim, pursuant to Section 8-43-303(1), C.R.S., the claimant must prove a worsening of his condition that is causally related to the industrial injury. Moreover, the worsened condition must warrant further benefits. *Cordova v. Indus. Claim Appeals Office,* 55 P.3d 186 (Colo. App. 2002); *Richards v. Indus. Claim Appeals Office,* 996 P.2d 756 (Colo. App. 2000). The reopening authority under the provisions of Section 8-43-303 is permissive, and whether to reopen a prior award when the statutory criteria have been met is left to the discretion of the ALJ. *Renz v. Larimer County Sch. Dist. Poudre R-1,* 924 P.2d 1177 (Colo. App. 1996). A claimant has the burden of proof in seeking to reopen a claim. *Cordova v. Indus. Claim Appeals Office, supra.*

3. It is well established that a change in condition refers to a change in the claimant's physical or mental condition, which is causally related to the underlying industrial injury. *Jarosinski v. Indus. Claim Appeals Office*, 62 P.3d 1082 (Colo. App. 2002); *Cordova v. Indus. Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002).

4. Claimant has failed to meet his burden in demonstrating a worsening of condition from the November 11, 2005. date of MMI. Claimant underwent three MRIs on June 8, 2005, February 7, 2007, and March 2, 2009. The June 8, 2005, MRI showed chronic appearing anterior wedging of the L4, L2, and T12 vertebral bodies and mild to moderate degenerative disc disease of the lumbar spine with relative sparing of the L4-L5 disc. However, the last two MRIs of February 7, 2007, and March 2, 2009, remained unchanged from Claimant's June 8, 2005, MRI. In this case, there is no objective pathology on the MRI to show that Claimant has sustained a worsening of his low back condition.

5. Claimant's condition at MMI included pain that averaged 7-8/10 on the pain scale. The evidence established that Claimant's complaints of pain have not changed. At Claimant's follow up appointment with Dr. Hattem on January 18, 2007, Claimant's pain complaints were 7-8/10, at the DIME with Dr. Bissell, Claimant's pain complaints were 7/10, and at Claimant's IME with Dr. Richman on December 12, 2008, Claimant's pain complaints were 5-8/10. At Claimant's follow up evaluation with Dr. Hattem on February 19, 2009, Claimant's pain complaints were 7/10. Additionally, Dr. Hattem testified that Claimant's pain complaints remained the same through pre and post MMI treatment. By Claimant's own credible account, his condition has not worsened as Claimant's pain complaints remain the same and Claimant still has the same function he had when he was placed at MMI and at the DIME with Dr. Bissell.

6. Moreover, Claimant's basis for his worsening claim are his subjective testimonials regarding that his low back condition has worsened and that he has developed an alleged depressive condition. When compared to his condition at the time of MMI, the evidence established that there is no substantive change or worsening of condition. Claimant testified that Dr. Richman was the first person to diagnose him with depression. However, at the time Claimant filed his Application for DIME on April 4, 2007, Claimant already thought that he might have some psychological problems because this was alleged as a condition to be evaluated by the DIME physician, Dr. Bissell.

7. Dr. Hattem credibly testified that frustration can lead to depression. At the time of the DIME, Claimant was frustrated regarding his low back pain and frustrated that his case had not yet settled. At hearing, Claimant testified that he was frustrated that he had not settled and that litigation has been going on for four and half years. The evidence established that Claimant was frustrated and stressed as of January 18, 2007, that his case had not settled, and this was the cause of his depression and not his alleged chronic pain because he had had the same pain complaints and lack of function since being placed at MMI on November 10, 2005.

8. In this case, Claimant's depression is not caused by his chronic pain. It is caused by litigation stress because he is frustrated that his case his not over after four and half years. However, litigation stress (negative psychological reaction to the litigation process) is not compensable. Litigation stress is an intervening event, not a compensable consequence of the work-related injury. *Jarosinski v. Indus. Claim Appeals Office,* 62 P.3d 1082 (Colo. App. 2002).

9. Therefore, it is concluded that Claimant failed to demonstrate by a preponderance of the evidence that his condition has worsened since the date of MMI.

ORDER

It is therefore ordered that:

Claimant failed to prove that his condition has worsened since the date of MMI. Claimant's petition to reopen is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: October 30, 2009

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-529-050

ISSUES

The issues to be determined by this decision are: Whether Claimant's claim is closed by operation of law, including application of the statute of limitations.

FINDINGS OF FACT

1. Claimant sustained admitted injuries covered by this claim on January 29, 2002. Claimant reached maximum medical improvement (MMI) in this claim on May 22, 2003, and Respondents' filed a final admission of liability (FAL) on September 26, 2003. That FAL admitted to medical benefits, and permanent partial disability (PPD) benefits. It denied maintenance medical benefits, and did not admit to any temporary total disability or temporary partial disability benefits.

2. Claimant filed an Application for Hearing (AFH) on October 20, 2003, endorsing the issues of: Medical Benefits: authorized provider; reasonably necessary; related to injury; treatment after MMI; average weekly wage; disfigurement; TTD from March 29, 2002 until May 22, 2003; TPD benefits from January 29, 2002 to May 22, 2003; travel expenses; unpaid medical bills. Claimant filed a new hearing application, endorsing the same issues endorsed in his October 20, 2003, hearing application, on February 11, 2004.

3. No hearing was held on Claimant's February 11, 2004, hearing application. C.R.S. 8-43-209 mandates that hearings commence within eighty to one hundred days

from the date of the hearing application's filing. No request for an extension of that deadline was filed or granted.

4. Claimant next filed an AFH on January 5, 2009. This hearing application endorsed only the issues of penalties and PPD benefits. The issues endorsed in Claimant's 2003 and 2004 hearing application were not endorsed for hearing.

5. Claimant's attorney withdrew that hearing application without any reservation of issues on February 4, 2009.

6. On March 20, 2009, Claimant filed another AFH. This application endorsed unspecified medical benefits, TTD for unspecified dates, and PPD benefits. Claimant did not file, and has never filed, a Petition to Reopen this claim.

7. Respondents last paid any medical benefit in this claim on March 24, 2005.

8. Respondents last paid any indemnity benefit in this claim on November 7, 2003, when they paid Claimant $196.53 to complete his PPD benefit's payments. The FAL show's Claimant's PPD benefits were payable through October 25, 2004. Claimant's PPD benefits were paid out earlier because Claimant requested the lump sum of PPD.

CONCLUSIONS OF LAW

a. Workers Compensation Rule of Procedure 7-1 (A) states "A claim may be closed by order, final admission, or pursuant to paragraph (C) of this section." Paragraph (C) applies only in circumstances where a party has requested that a claim be closed. Therefore, a case can only be closed in 3 ways by order, final admission, or request of a party.

b. A final admission will close a claim if the Claimant fails to timely object, but only as to the issues admitted. *Dalco Industries, Inc. v. Garcia*, 867 P.2d 156 (Colo.App. 1993). An objection to the final admission must be made within 30 days of the date of the final admission. West's C.R.S.A. § 8-43-203(2)(b)(II). If a Claimant fails to object to a final admission they are deemed by law to agree with the benefits addressed in the final admission. *Dalco Industries, Inc. v. Garcia*, 867 P.2d 156 (Colo.App. 1993). A final admission is effective in closing a claim only if it complies with the statute and the Rules of Procedure. Rule of Procedure, & CCR 1101-3, Rule 5-5 and Rules of Procedure, 7 CCR 1101-3,3 Rule 7-1.

c. A case that has not been closed properly remains open indefinitely, there is no requirement that a worsening condition must be proved when the Claimant seeks additional benefits and the case has not been closed pursuant to law. *El Paso County Department of Social Services v. Donn*, 865 P.2d 877 (Colo.App. 1993).

d. Claimant timely objected to the FAL on October 20, 2003 and filed an Application for Hearing on *inter alia*, the issues of medical benefits and temporary total disability (TTD benefits).

e. The issues of medical benefits and TTD were never closed by order or FAL or request of a party.

f. Once the Claimant objected to the issues of medical benefits and TTD and applied for hearing, those issues could no longer be automatically closed by operation of law. Only by an affirmative action on the part of one or both of the parties could those issues be closed.

g. Respondents did not request closure of the claim for abandonment nor follow those procedures for closure.

h. Respondent's failed to properly close the claim and therefore, it remains open on the issues of medical benefits and TTD.

ORDER

It is therefore ordered that:

1. Respondents' request to have the claim herein determined to be closed is denied and dismissed.
2. All matters not determined herein are reserved for future determination.

DATE: October 30, 2009

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-695-024

ISSUES

The issue for determination is the relatedness of physical therapy treatment recommended by Dr. Roger Sung.

FINDINGS OF FACT

1. On July 24, 2006 the Claimant suffered an admitted work-related injury involving his cervical spine and right knee.

2. The Claimant was treated and found to be at maximum medical improvement on June 26, 2008. The primary authorized treating physician, Dr. Dwight K. Caughfield pro-

vided his impairment rating of 20% whole person for the cervical spine and 19% lower extremity scheduled impairment for the knee. The impairments were incorporated into the Final Admission of Liability dated July 29, 2008. The Final Admission of Liability admitted for reasonable and necessary maintenance care.

3. Dr. Roger Sung is an authorized treating physician and has recommended physical therapy for the Claimant's neck to maintain maximum medical improvement. Respondents denied physical therapy as not being related.

4. The parties stipulated at hearing that the sole issue for determination is relatedness of physical therapy.

5. On March 11, 2009 Dr. Roger Sung saw the Claimant. Dr. Sung noted that the Claimant was having mild residual neck pain. Dr. Sung also noted that the Claimant hit a drainage ditch while driving and since that time the neck pain has flared and has caused the Claimant a little worsening of his headaches. Dr. Sung prescribed the physical therapy, which was denied.

6. The Claimant underwent a C5-C7 fusion by Dr. Roger Sung as a result of the industrial injury in January of 2007. Subsequently, medical records document that part of the hardware screws were broken. This was determined by x-ray examination on April 16, 2008. The Claimant testified credibly that he has continued to have pain and headaches subsequent to the surgery. The event involved with hitting the drainage ditch was simply described as a mild aggravation. The Claimant had planned to seek additional treatment from Dr. Sung prior to this event. The Claimant testified credibly that he did not leave the road or strike any object. He simply hit a low spot in the road.

7. The ALJ concludes, based upon a totality of the evidence, that the recommended physical therapy is reasonable, necessary, and related to Claimant's original work injury of July 24, 2006. The Claimant's testimony is credible and persuasive.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ draws the following Conclusions of Law:

1. The purpose of the Workers' Compensation Act of Colorado ("Act"), §§8-40-101, et seq., C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. The Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case must be interpreted neutrally, neither in favor of the rights of the Claimant nor in favor of the rights of respondents. Section 8-43-201.

2. When determining credibility, the fact finder shall consider, among other things, the consistency or the inconsistency of the witnesses' testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936). A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

3. The Claimant was required to prove by a preponderance of the evidence that the conditions for which he seeks medical treatment were proximately caused by an injury arising out of and in the course of the employment. Section 8-41-301(1)(c), C.R.S. The Claimant must prove a causal nexus between the claimed disability and the work-related injury. *Singleton v. Kenya Corp.*, 961 P.2d 571 (Colo. App. 1998). The question of whether the Claimant met the burden of proof to establish the requisite causal connection is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000).

4. As determined in Findings of Fact 7, the Claimant proved it is more probably true than not that the need for the physical therapy proposed by Dr. Roger Sung is causally related to the industrial injury of July 24, 2006. The Claimant's ongoing symptomatology after surgery and reaching maximum medical improvement is more likely than not directly related to the industrial injury. The physical therapy recommended by Dr. Roger Sung is more likely than not to treat this ongoing symptomatology related to the industrial injury.

ORDER

It is therefore ordered that:

The Respondents shall pay for the physical therapy recommended by Dr. Roger Sung and all reasonable and necessary expenses associated with that treatment.

All matters not determined herein are reserved for future determination.

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, Colorado, 80202. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within

twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

DATE: October 30, 2009

Donald E. Walsh
Administrative Law Judge